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ANNUAL MEETING, MAY 21, 22 and 23, 1946
CLARIDGE HOTEL, ATLANTIC CITY

THE JOURNAL

OF

THE MEDICAL SOCIETY OF NEW JERSEY

Place of Publication, Printing and Mailing:
12 SOUTH DAY STREET, ORANGE, NEW JERSEY

Entered as second-class matter, September 5, 1906, at the post office at Orange, New Jersey, under Act of March 3, 1879.

VOL. 43, No. 1 — JANUARY, 1946 — Subscriptions, $3.00 per Year
Single Copies, 30 Cents

F2
1946

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Editorial and Executive Offices of the Society
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PLACE OF PUBLICATION, PRINTING AND MAILING, 12 SO. DAY ST., ORANGE, N. J.
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1946

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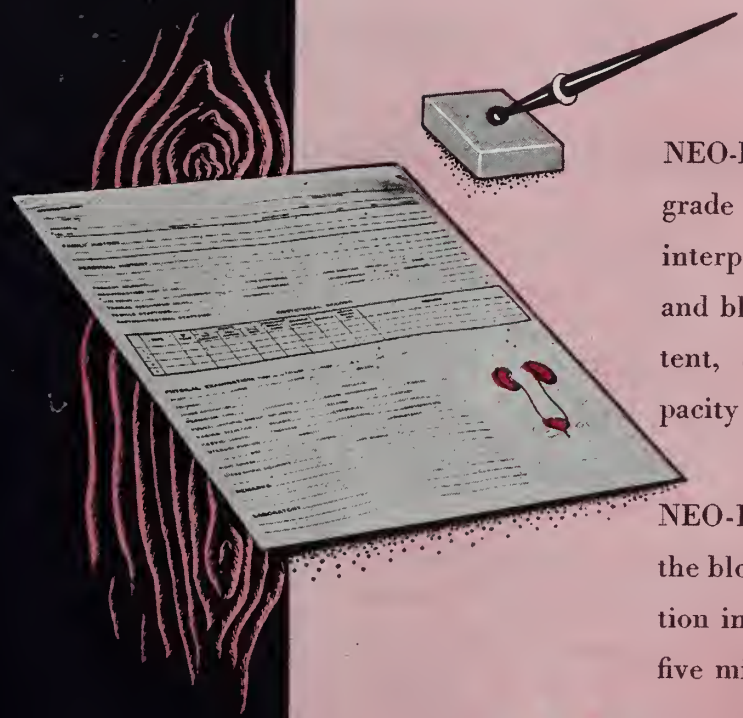


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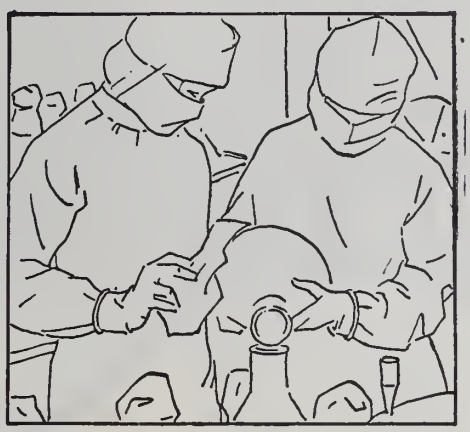
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There came to him a young man, who had spent much but got little, and said: "Tell me, Wise One, what shall I do to receive the most for that which I spend?"

Hakeem answered: "A thing that is bought or sold has no value unless it contains that which cannot be bought or sold. Look for the Priceless Ingredient."

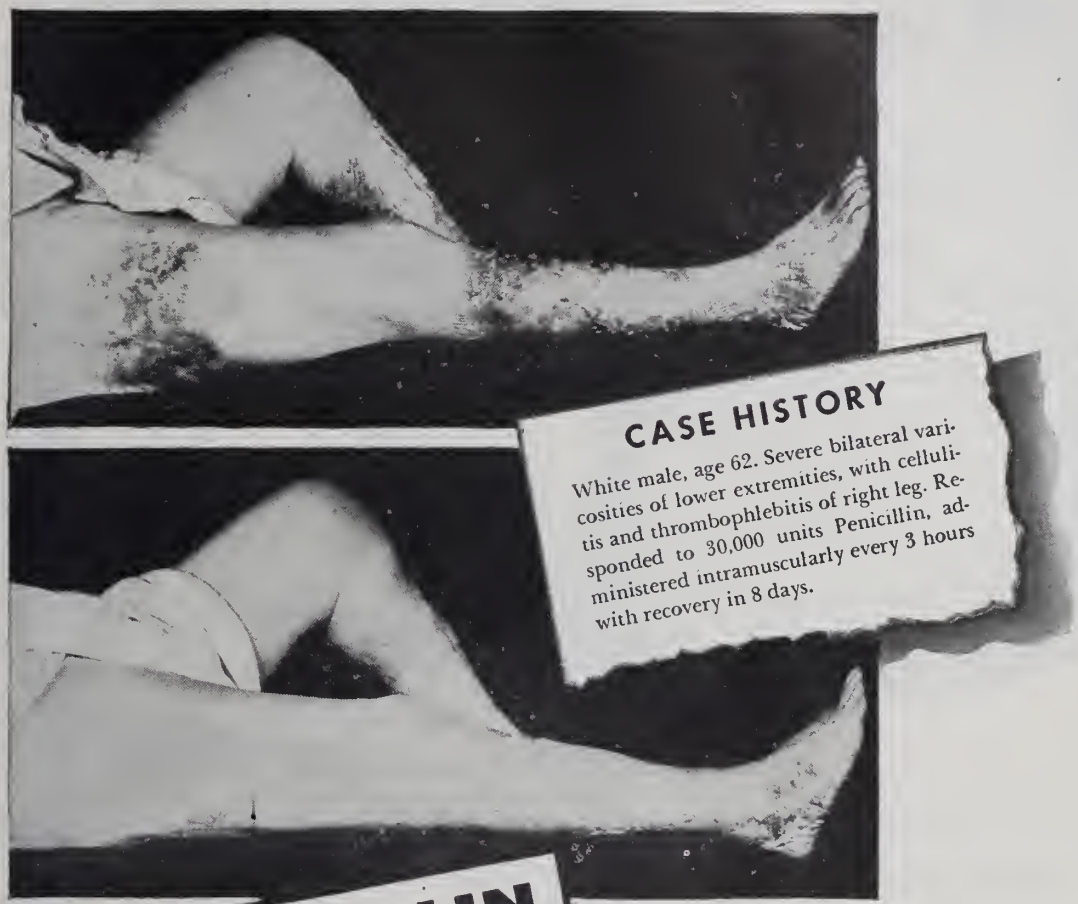
"But what is this Priceless Ingredient?" asked the young man.

Spoke then the Wise One: "My son, the Priceless Ingredient of every product in the market-place is the Honor and Integrity of him who makes it. Consider his name before you buy."

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*Keefer C. S. et al.: New Dosage Forms of Penicillin, J.A.M.A. 128: 1161 (Aug. 18) 1945.

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**Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154.*
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60.

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Fat %	1.5	0.9	2.1	0.9	0.5
Carbohydrate % by difference	6.4	7.5	7.2	7.6	9.3
Calories per ounce	14	15	17	15	14
Crude Fibre %	0.15	0.29	0.30	0.22	0.43
Calcium %	0.026	0.013	0.046	0.046	0.024
Phosphorus %	0.042	0.065	0.068	0.068	0.051
Iron Mg. per 100 g.	.22	.72	.35	.40	.73
Copper Mg. per 100 g.	.24	.35	.12	.17	.24
Manganese Mg. per 100 g.	.075	.173	.054	.053	.018
Vitamin A—I. U Per 100 g.	1766	7000	1130	1693	2550
Thiamine Mg per 100 g.	018	.080	.036	.037	.069
Riboflavin Mg. per 100 g.	.040	.62	.068	072	.064
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Niacin Mg. per 100 g	.77	1.54	1.22	1.29	1.05

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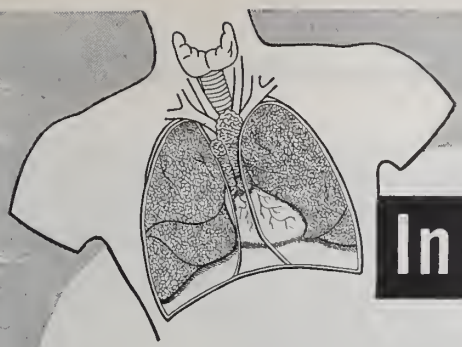
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1. Human Fertility, 10:25, March, 1945.

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*Stainsby, W. J.; Foss, H. L., and Drumheller, J. F.: Clinical Experiences with Penicillin, Pennsylvania M. J. 48:119 (Nov.) 1944.

McBryde, A.: Hemolytic Staphylococcus Pneumonia in Early Infancy; Response to Penicillin Therapy, Am. J. Dis. Child. 68:271 (Oct.) 1944.

Stainsby, W. J., Chairman, Commission for the Study of Pneumonia Control of the Medical Society of the State of Pennsylvania: Up-to-Date Facts on Pneumonia, Pennsylvania M. J. 48:266 (Dec.) 1944.

Larsen, N. P.: Observations with Penicillin, Hawaii M. J. 3:272 (July-Aug.) 1944.

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Penicillin-C.S.C. deserves the physician's preference not only in the pneumonias, but whenever penicillin therapy is indicated. Rigid laboratory control in its manufacture, and bacteriologic and biologic assays, safeguard its potency, sterility, nontoxicity, and freedom from pyrogens. The state of purification reached in Penicillin-C.S.C. is indicated by the notably small amount of substance required to present 100,000 Oxford Units. Because of this purity, incidence of the undesirable reactions, attributed by many investigators to inadequate purification, is greatly reduced.

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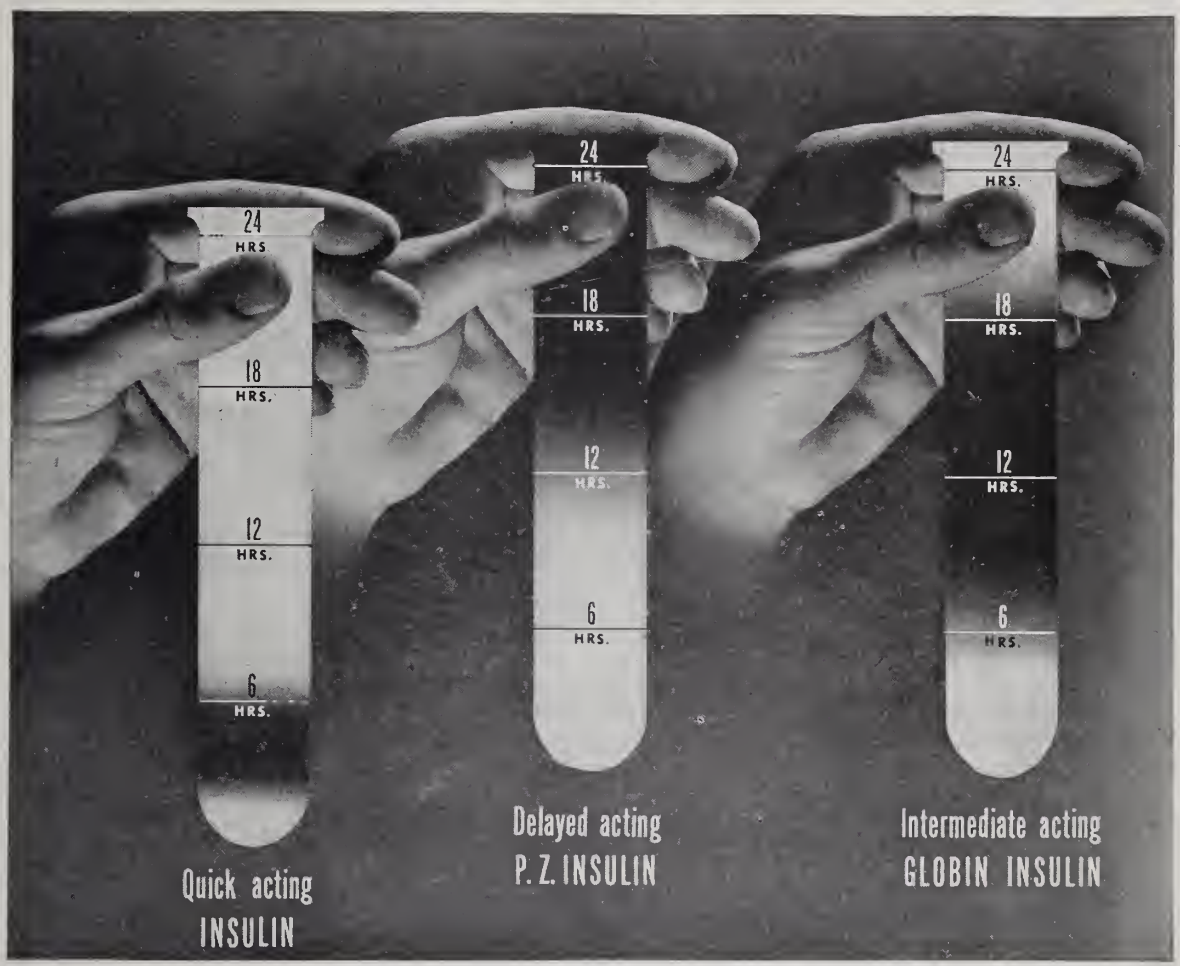
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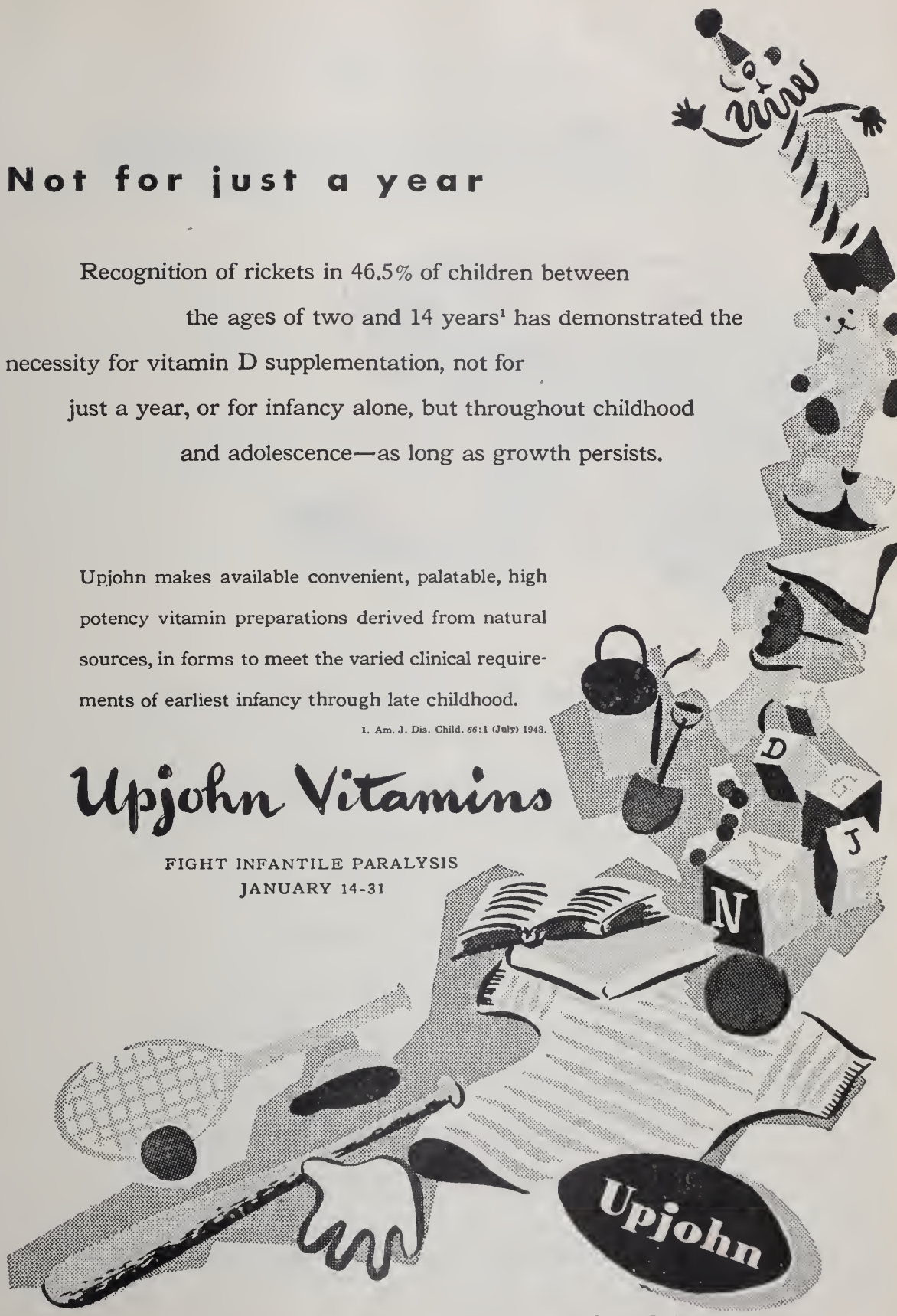
Recognition of rickets in 46.5% of children between the ages of two and 14 years[1] has demonstrated the necessity for vitamin D supplementation, not for just a year, or for infancy alone, but throughout childhood and adolescence—as long as growth persists.

Upjohn makes available convenient, palatable, high potency vitamin preparations derived from natural sources, in forms to meet the varied clinical requirements of earliest infancy through late childhood.

1. Am. J. Dis. Child. *66*:1 (July) 1943.

Upjohn Vitamins

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Adequate rest is an important factor in the successful treatment of upper respiratory infections. Frequently, nasal congestion keeps the patient irritable and sleepless. Solution 'Tuamine Sulfate' (2-Amino-heptane Sulfate, Lilly), administered by spray or dropper, quickly shrinks the nasal mucosa, permitting easy, natural breathing. There is no secondary engorgement or central-nervous-system stimulation. Specify Solution 'Tuamine Sulfate,' 1 percent, for home use. The 2 percent solution is recommended for office procedures in which maximum shrinkage is required.

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THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

PUBLISHED MONTHLY SINCE SEPTEMBER, 1904
Whole Number of Issues, 497

UNDER THE DIRECTION OF THE COMMITTEE ON PUBLICATION

HENRY C. BARKHORN, M.D., Chairman

HENRY A. DAVIDSON, M.D., Editor

Place of Publication, Printing and Mailing—12 South Day Street, Orange, N. J.
Editorial and Executive Offices of the Society—315 West State Street, Trenton 8, N. J.; Tel. 5776
Each member of the State Society is entitled to receive a copy of THE JOURNAL every month.

VOL. 43, NO. 1 JANUARY, 1946 Subscriptions, $3.00 per Year
Single Copies, 30 Cents

EDITORIALS

1946 ANNUAL MEETING

The Medical Society of New Jersey, completing its 180th year of existence, will hold its Annual Meeting on May 21, 22 and 23, 1946, at the Claridge Hotel, Atlantic City. This event promises to be one of the best attended and one of the most important meetings in the history of the Society.

For many of the doctors returning from the armed forces, the meeting at Atlantic City will give an opportunity to renew old friendships and meet again many of the members who have been carrying their portion of the war burden in other fields of service.

There never was a time when the problems facing Organized Medicine were of such prime importance as they are at present. The two most important ones that will be under consideration will be:

1. Plans providing for the full utilization of our Medical-Surgical Plan and Medical Service Administration by the people of New Jersey;

2. Plans to make effective a program with the Veterans Administration which will insure adequate medical care to veterans suffering from service--connected disabilities and to the others covered by the G. I. Bill of Rights.

These two problems affect every physician in our state, and while the House of Delegates is the official legislative body for the Society, every doctor will be obliged to do his part in solving them to the mutual satisfaction of the public and the profession at large.

General sessions for the members will be held on Tuesday afternoon, May 21, and Thursday morning, May 23. These meetings will be addressed by noted speakers who will bring important messages. On Wednesday, May 22, excellent scientific programs in the various sections have been formulated and these section meetings will be well attended. The papers to be presented will be timely and instructive and will be open for discus-

sion. To avoid conflict in schedule no other programs are being projected for this day.

The Annual Banquet, to be sponsored by the Woman's Auxiliary on Wednesday evening, May 22, will undoubtedly be one of the highlights of the convention, and the brilliant social event of the meeting.

The actual participation by the individual physicians in the various phases of the meeting will prove both beneficial and inspiring.

Watch your *Journal* for future announcement concerning the meeting and the programs of the scientific sections and the general sessions.

Samuel Alexander, M.D.,
President.

THE DOCTOR AND PSYCHOSOMATICS

Increasing interest in psychosomatics bespeaks an increasing need for doctors with an "overall" point of view. Thus, according to the psychosomatic philosophy, the emotional climate of the patient is as important as his bacteriologic or meteorologic climate. But if the practitioner must concern himself as much with the ideas which his patient takes in as he has always concerned himself with the bacteria he absorbed, then obviously the doctor must have a corresponding familiarity with those ideas.

Hence it is a matter of legitimate interest for the physician to know what comes over the radio in his patient's living room, what ideas are implanted by the newspapers which his patients read. Medical practice ceases to be an art of the sickroom or laboratory only and becomes, in addition, an art of the total community. The doctor's isolation from society at large is as sterile as political isolation in the one world today. The pediatrician, for example, who knows all about feeding formulas, but nothing about the comic strips which his young patients read, is seeing only half the picture. These "funnies" certainly exercise an influence on the child's emotions and psychosomatics is dedicated to the thesis that whatever affects the psyche, also affects the soma. The cardiologist must know more than murmurs. He must know whether keeping up with the Joneses exercises a detrimental influence on the pace of life and therefore on cardiac efficiency; and by the same token, he must know just what kind of standards the Joneses are setting. The doctor cannot understand his patient unless he understands the community in which his patient is immersed.

But it goes beyond understanding the mechanism of an illness. The doctor's job after all, is to help the patient. And if psychosomatics means anything, it means that manipulating the social and emotional forces which rain down on the patient is an essential part of "overall" therapy. A doctor may advise a widowed mother to seek the financial or emotional security of a job. If she cannot accept work unless she finds a day nursery in which to place her children, then the doctor's job must include knowing where (or at least, how) to find such a nursery. To prescribe a hobby is empty advice unless the practitioner also knows how the patient can get the instruction and facilities which that hobby requires. What the physician needs, in a word, is a sort of communal "know-how". It comes back, of course, to the basic point: that the doctor today must know the total community. Anything short of that is the treatment of diseases, not the treatment of people.

MEDICAL CARE OF THE VETERAN

The Medical Society of New Jersey is of the opinion that organized medicine should concern itself with and should assume a large measure of responsibility for the medical care of the returned wounded and physically unfit veterans of our armed forces.

The United States Veterans Administration proposes that war veterans suffering from "service-connected" disabilities and diseases be cared for by civilian physicians of their own choice, in the offices of such physicians, in the homes of veterans and in our community hospitals.

It is estimated that there will be 600,000 World War II veterans and 120,000 World War I veterans in New Jersey, of whom about 30 per cent will have service-connected disabilities.

Definite steps have been taken by the Society to evolve a program for the care of New Jersey veterans, utilizing our agency, Medical Service Administration, to handle the financial side of the program and to coördinate the activities within the counties at a state level.

Such a program, in evolutionary form, is now ready for presentation to the United States Veterans Administration, and we hope to announce a completed program acceptable to the Veterans Administration and the Society in the next issue of the *Journal*.

In the meantime, all members of the Society will receive a request from the President of the Society to participate in the program. General Paul Hawley has stated that he will deal only with members of County Medical Societies. It is hoped that every member will express a willingness to participate and be listed as a "Designated Physician of Veterans Administration".

Here is a challenge to organized medicine. A problem has been placed in our lap. Our ability or lack of ability to solve this problem is the most important public relations program ever faced by the profession and the results may be an important factor in determining the future status of the medical profession. Let's Go.

MEETING OF THE AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

A meeting of the American Medical Association House of Delegates would be an inspiration to any physician who has never attended such a session; in fact, each session is an inspiration to each of those physicians who has attended the sessions for years.

The recent session was no exception. Among the Delegates was the best talent the profession has to offer to guide solutions for the critical problems facing us and evidence of this talent was reflected in the words and action of this body of free men.

All of their words and actions expressed a firm determination that medicine of the future would be practiced in accordance with the principles of individualism rather than those of collectivism.

There were two particularly inspiring episodes during the session. The first was the result of the presentation by Major General Hawley of the problem of the medical care of the veterans. It was simple, sincere and informal, emphasizing the fundamental moral and ethical obligation he felt toward the veteran and the profession. He expressed in all sincerity

his allegiance to the veteran and the medical profession and promised that any solution of the problem in which he played a part would betray neither the veteran nor the profession. He placed the medical care of the veteran in the hands of the profession. Such a frank, sincere talk from a physician in government service inspired the thought and assurance that we are not without friends in Washington.

The second inspiring and encouraging moment resulted from the unanimous action of the House of Delegates to promote a national health plan in the name of the medical profession to combat the collectivists' threat of national compulsory sickness insurance. This action was enthusiastically greeted and supported by every delegate as the first step of a constructive program by organized medicine on a national basis to meet the current demand for an improvement in medical care distribution.

One left the session with a renewed faith in the medical profession and a deep pride in the type of man making up the House of Delegates of the American Medical Association.

The welfare of the profession and the health problems of our people are in good hands.

OUR EDITOR IS BACK

The Society's own reconversion takes a step onward with the return this month of our *Journal's* Editor. Dr. Davidson sought a commission in December, 1941, immediately after Pearl Harbor, and in May, 1942, then a Lieutenant in the Medical Corps, he was sent to Australia as Registrar of an Army Hospital. In December, 1942, he was promoted to Captain. After a year and a half in Australia, he was transferred to New Guinea to serve as Executive Officer of a psychiatric hospital in that South Sea island. In September, 1944, he was promoted to Major and two months later, after almost three years of foreign service, was called back to the U. S. A. to serve as an instructor at the Army's School of Military Psychiatry. Having completed four years of service, most of it in the Southwest Pacific theater, Major Davidson was released from active duty to return to civilian practice. The Publication Committee welcomes him back and looks forward to the maintenance of the top-notch standards of copy selection, *Journal* make-up and vigorous editorial policy which characterized his prewar incumbency of the editorial chair.

In the era now beginning, Organized Medicine faces a period of unusual pressures and must constructively meet many novel problems in the field of medical personnel and medical practice. It is in providing an arena for the discussion and presentation of such problems, that the *Journal* looks for its greatest field of future usefulness.

Henry C. Barkhorn, M.D.,
Chairman,
Publication Committee.

ORIGINAL ARTICLES

NEUROSYPHILIS: ITS DIAGNOSIS AND TREATMENT*

Hilton S. Read, Lt. Col.
Lawrence I. Kaplan, Capt.
Frederic T. Becker, Maj.
Medical Corps, Army of the United States

Neurosyphilis, a social, economic and medical problem of significant import, should concern the rank and file of practitioners as much as cancer, tuberculosis, poliomyelitis and other headliners on the national health stage. A concerted attack by an informed and aggressive profession should pay handsome dividends in health, happiness and lower taxes.

Luetics form a sizeable segment of our institutionalized mental patients. More exist at a sub-employment level, dependent on relatives and friends for food and shelter. Many could have been spared this experience had early recognition and prompt and thorough treatment been available. The more serious forms of the disease are ten times as frequent in the irregularly treated group.[1]

Communications such as these should perhaps not editorialize, and that is not our intent. Nor is it our delusion that one short paper can cover the subject adequately. Our hope is that general practitioners will mobilize, as they have in other medical crusades, and stamp out this cause of morbidity and mortality. The recent introduction of newer drugs and techniques justifies this sketchy reorientation.

The central nervous system is involved early in syphilis. The cerebrospinal fluid is affected at the time of the secondary rash and often as early as four weeks after infection. The involvement may be manifested only by a moderately severe, transitory headache. Twenty-five to 40 per cent of the spinal fluids will show abnormalities at this time. This does not mean necessarily that 25 to 40 per cent of syphilitics will become paretics or tabetics, for many of the fluids will sterilize themselves spontaneously and many more will be converted to normal by treatment. What it does mean is that syphilitics should be thoroughly and uninterruptedly treated by orthodox techniques, and that follow-up examinations of the cerebrospinal fluid should be routinely performed, without special indication, six months after completion of treatment, and then at least once yearly. No luetic patient should be discharged as cured unless the spinal fluid examination has been performed. Menninger and Bromberg [2] reported 31 per cent of 500 neurosyphilitic patients had a negative blood Wassermann, indicating the importance of this examination. An asymptomatic luetic with a normal cerebrospinal fluid four years post-infection is unlikely to develop neurosyphilis, and routine cerebrospinal fluid examinations may be abandoned.

Neurosyphilis may be meningeal, vascular or parenchymatous. The three categories are not mutually exclusive and may co-exist in any perplexing combination. Neurosyphilis may be asymptomatic or symptomatic. Obviously it is desirable to recognize it in an asymptomatic stage. One will obtain the best results by the establishment of a high index of suspicion and by considering all luetics as having central nervous system involvement until proved otherwise.

History and physical examination are often misleading. They may indict the spirochete, but only the examination of the cerebrospinal fluid can sentence it. Such indicators as the Argyll Robertson pupil, unphysiological tendon reflexes, disturbed sensation, and difficulty in speech or walking in the dark, are notably deceiving. Twenty-eight per cent of Dattner's

* From the Neurosyphilis Center, Finney General Hospital, Thomasville, Ga.
Prepared for presentation at the Atlantic County Medical Society, Atlantic City, N. J., October 12, 1945.

1. Moore, J. E.: The Modern Treatment of Syphilis. Springfield, Illinois; Charles C. Thomas, 1933.
2. Menninger, W. C., and Bromberg, L.: J. Lab. & Clin. Med. 20:383, 1935.

patients had no pupillary changes [3] and 29.5 per cent of Lowrey and Benedikt's [4] had normal knee and ankle jerks. The anatomical diagnosis of the central nervous system pathology is essential, but the etiological diagnosis is even more important, for the treatment of neurosyphilis has much to offer.

War Department Technical Bulletin TB Med 48, issued 31 May 1944, was entitled "Management of Neurosyphilis". Under "Diagnosis of Neurosyphilis" it states as follows:

"a. Asymptomatic neurosyphilis. This is neurosyphilis without symptoms or physical (neurologic or psychiatric) signs of the disease; the diagnosis is based on routine examination of the spinal fluid. The tests on which such a diagnosis depends are cell count; Pandy or Nonne-Apelt qualitative tests for protein; quantitative estimation of total protein content; complement fixation (Wassermann) test; and colloidal gold test.

(1) The Wassermann test is the only one of these specific for syphilis, and even this test, when unsupported by other spinal fluid abnormalities, requires repetition before acceptance as evidence for the diagnosis of asymptomatic neurosyphilis. If the Wassermann test is not definitely positive, other tests on the borderline of normality should be repeated after an interval of not less than two weeks in order to exclude technical error. In general, the diagnosis of asymptomatic neurosyphilis depends on the interpretation of the pattern of these five tests, rather than on normality or abnormality of any one of them.

(2) Asymptomatic neurosyphilis, early or late, may be conveniently divided into three groups, depending on the degree of the spinal fluid changes. Sample patterns of the spinal fluid in these three groups are as follows (these findings apply only to nonbloody spinal fluid):

Group	Pattern of Change	WBC per cu/mm.	Pandy or Nonne-Apelt	Total Protein	Complement Fixation	Colloidal Gold
I.	Minimal	8 or more	Negative or doubtful	5- 50 mg. per 100 cc.	Negative or doubtful	0000000000 to 2221000000
II.	Intermediate	8-200 or more	Doubtful to positive	40-100 mg. per 100 cc.	Doubtful to positive (with 1 cc. of fluid)	any type eg, 2211100000 0012210000 1123100000 3332100000
III.	Maximal	8-200 or more	Doubtful to positive	40-200 mg. per 100 cc.	Positive (with .1 to .5 cc. of fluid)	5554321000

"b. Symptomatic neurosyphilis. This diagnosis presumes that the patient has symptoms and/or neuropsychiatric signs of disease. In each instance, where symptoms or physical signs suggest such a diagnosis, appropriate serologic examinations of blood and cerebrospinal fluid aid in the clinical classification of the case. From the clinical standpoint, symptomatic neurosyphilis may be divided into five broad categories:

1. Acute syphilitic meningitis.
2. Diffuse meningovascular neurosyphilis (including such entities as 'cerebrospinal syphilis', gumma of the brain or spinal cord, etc.).
3. More or less purely vascular neurosyphilis (Hemipareses, etc.).
4. Tabes dorsalis.
5. General paresis."

Meningeal neurosyphilis manifests itself often as an acute meningitis. It usually occurs during the first year, but may even occur late in the disease as an accompaniment of parenchymatous neurosyphilis. Less than 5 per cent of luetics show this manifestation. It generally occurs in young individuals who have abandoned treatment after a few "shots". It is manifested by headaches, nausea, stiff neck, mental confusion, and cranial nerve palsies, and may be confused with epidemic meningitis. Examination of the cerebrospinal fluid establishes the etiology because it shows a positive serology, a marked elevation of cells up to 300 or 400 (even as high as 2100) with lymphocytes predominant, and an increase in the total protein and gobulin. It is readily amenable to chemotherapy, which, unfortunately, may mislead the patient and physician to abandon treatment prematurely. Treatment should be maintained for 18 months at least, with continued routine examination of the cerebrospinal fluid as previously mentioned.

Vascular neurosyphilis may develop at any time after the primary sore. The diagnostic signs or symptoms may be those of a space-occupying lesion or of arteriosclerosis. It

3. Dattner, B.: The Mangement of Neurosyphilis. New York, N. Y.: Grune & Stratton, 1944.
4. Lowrey, L. G., and Benedikt, M. K.: J. Nerv. & Ment. Dis. 52:106, 1920.

should be considered in a young individual, without hypertension or cardio-vascular-renal disease, who experiences an episode simulating the result of a cerebrovascular accident, or neoplasm. It can also mimic multiple sclerosis, spinal cord tumors and any form of myelitis. The diagnosis is aided by a positive blood Wassermann test or the history of one. The findings in the cerebrospinal fluid may be entirely negative if the lesion is deep-seated. The findings may be those of a brain or spinal cord tumor, or the reaction may be meningeal in type, according to the location of the pathology. Chemotherapy is the proper approach. The degree of functional recovery depends on how much the symptoms were due to: (a) edema, and (b) the size and number of thrombosed vessels.

Early asymptomatic neurosyphilis with Group I and II spinal fluid changes, of less than two years' duration of infection, and *late asymptomatic neurosyphilis* with Group I fluid changes, present more than two years, or Groups I and II, duration unknown, should be put on chemotherapy for six months, after which there should be a reappraisal of the spinal fluid. If improvement in the spinal fluid is not shown by that time, or progression has occurred, the patient should be given fever therapy. In addition to these patients who have responded unfavorably to chemotherapy, patients with early asymptomatic neurosyphilis, Group III fluid, and late asymptomatic neurosyphilis with Group II or III fluids, should have malaria therapy.

Late symptomatic parenchymatous neurosyphilis usually takes the form of paresis or tabes but may be manifested as primary optic atrophy or chronic anterior poliomyelitis. The discovery of a positive cerebrospinal fluid (which really is a mirror of the parenchymatous pathology) in an asymptomatic luetic, should cause appropriate treatment to be promptly instituted and continuously enforced.

A nicety of judgment is involved in the treatment. Consideration has to be given to fever therapy alone or in combination with chemotherapy, including penicillin. Acute syphilitic meningitis, diffuse meningovascular neurosyphilis or vascular neurosyphilis should not be given malaria, unless improvement fails to occur after at least six months of chemotherapy.

The diagnostic classification of 591 admissions to this Neurosyphilis Center during the past 13 months is shown in Table I.

TABLE I

TOTAL ADMISSIONS		591
NEUROSYPHILIS		411
Asymptomatic	291	
Group I	8	
Group II	65	
Group III	218	
Meningovascular	72	
Syphilitic Meningitis	7	
Vascular Neurosyphilis	9	
Optic Atrophy	5	
Transverse Myelitis	4	
Diffuse Meningovascular	47	
Tabes Dorsalis	25	
Early	16	
Late	9	
General Paresis	21	
Tabo-Paresis	2	
OTHER FORMS OF SYPHILIS		147
Early Latent	44	
Late Latent	50	
Ocular	7	
Cardiovascular	7	
Secondary	6	
Cured	19	
Miscellaneous	14	
OTHER DISEASES		12
READMISSIONS		12
NOT COMPLETELY INVESTIGATED		9

The examination of the cerebrospinal fluid should be done promptly by qualified personnel. The cell count and the globulin, or Pandy test, should almost become bedside procedures.

We have described [5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16] various aspects of the use of malaria ther-

5. Becker, F. T.; Kaplan, L. I., and Read, H. S.: Variations in Susceptibility to Therapeutic Malaria. (Accepted for publication in the American Journal of Medical Sciences.)
6. Read, H. S.; Kaplan, L. I., and Becker, F. T.: An Analysis of Complications Encountered During Therapeutic Malaria. (Accepted for publication in the Annals of Internal Medicine.)
7. Read, H. S.; Becker, F. T., and Kaplan, L. I.: Malaria —Man's Friend. (Accepted for publication in Hygeia.)
8. Kaplan, L. I.; Read, H. S., and Mullins, D. F.: Spontaneous Rupture of the Spleen During Therapeutic Malaria. (Accepted for publication in the Annals of Internal Medicine.)
9. Kaplan, L. I.; Flicker, D.; Becker, F. T., and Read, H. S.: Acute Psychosis Following Therapeutic Malaria in a Case of Neurosyphilis. Jr. Nerv. & Ment. Dis., September 1945.
10. Kaplan, L. I.; Read, H. S., and Becker, F. T.: Syphilitic Meningitis with Negative Blood and Spinal Fluid Serologic Tests. (Approved for publication.)
11. Glenn, P. M.; Kaplan, L. I.; Mullins, D. F., and Read, H. S.: Clinical and Laboratory Studies of Liver Function in Therapeutic Malaria. (Recently submitted for publication.)
12. Kaplan, L. I.; Read, H. S.; Becker, F. T., and Boyd, M. F.: The Use of Quantitative Parasite Inoculation Dosages in Therapeutic Vivax Malaria. (Accepted for publication in the Archives of Neurology and Psychiatry.)

apy in neurosyphilis. Attempt will now be made only to highlight some of the features of this therapy. The absolute contraindications to fever therapy are tuberculosis, nephritis, and advanced cardiac disease with decompensation. Latent tuberculosis may be activated. We have given malaria therapy without incident to a patient who had previously experienced a myocardial infarction and to one with aortic insufficiency. Relative contraindications depend upon the conscience of the therapist.

The preinoculation work-up includes a complete history, physical, neurological, ophthalmological, dental, and mental examination. The auxiliary aids employed should include a blood Wassermann test, spinal fluid examination as previously described, urinalysis, blood count, urine concentration test, blood N. P. N., icteric index, total serum proteins, chest x-ray, and an electrocardiogram.

Malaria therapy may be induced either by the inoculation of trophozoites from the blood of an individual suffering with malaria, or of sporozoites through the bite of a malaria-infected mosquito. The mosquito technique of artificially-induced malaria produces a reaction more nearly resembling natural malaria. It has certain disadvantages. An insectarium must be maintained, mosquitoes must be dissected to determine their infectivity, and recurrences are not infrequent, occurring more readily than in the trophozoite-induced disease.

Problems in individual immunity are sometimes encountered. Vivax malaria is the species of choice in white individuals who have not had a previous experience with malaria. Quartan malaria should be reserved for those white individuals who previously had malaria, and for all Negroes, Puerto Ricans, and individuals of Mediterranean nativity. Falciparum malaria should almost never be used and then only when ideal laboratory and clinical control are possible and where inoculations with Vivax or Quartan have failed. Spontaneous remissions may be encountered in any of the three species before the desired number of paroxysms have been obtained, so that reinoculation may be necessary. If less than five Vivax paroxysms have been obtained, the patient should be reinoculated with Plasmodium Malariae (Quartan), but if more than five paroxysms have been obtained, a sufficient number of additional paroxysms may be produced by the use of a heterologous strain of Vivax. Primary quartan inoculations seldom require reinoculation.

We have elsewhere described the mode of inoculation and the quantitative parasite dosage, and their influence on the incubation period, the prepatent period, and the clinical course of the disease. Suffice it to say that our present opinion is that quantitative parasite counts are highly desirable for the proper management of therapeutic malaria, and that intravenous inoculations of 1 to 2 million trophozoites (Vivax) induce the most desirable clinical course. Counts of Vivax, for instance, may run 15,000 to 25,000 per cubic mm. at the height of the parasitemia, and if blood is taken then, which it seldom is, it would be necessary to give only 1/10th of a cc. of blood intravenously in order to introduce 1½ to 2½ million parasites. However, the counts vary so unpredictably after approximately the fifth paroxysm that it is impossible to say how much blood to give unless one is using quantitative parasite counts. The incubation and prepatent period may be reduced to zero by mass inoculation (50 to 100 million trophozoites). It would appear that large doses of trophozoites are in some way also related to the period of remittent fever that so often initiates the clinical activity in therapeutic malaria. This period may vary from 12 to 120 hours and may so exhaust the patient at the very beginning of his therapy as to make him a physical, psychological and morale problem throughout the treatment.

Intradermal inoculations more nearly mimic natural malaria and are more apt to produce a tertian cycle from the onset. We were dis-

13. Kaplan, L. I.; Read, H. S.; Becker, F. T., and Boyd, M. F.: Homologous and Heterologous Strains of Plasmodium Vivax: A Cross Inoculation Study of Malaria Strain Immunity. (Accepted for publication in The Journal of Laboratory and Clinical Medicine.)
14. Kaplan, L. I.; Read, H. S.; Becker, F. T., and Seymour, C. F.: The Concentration of Penicillin in the Spinal Fluid Following Intramuscular Administration in Neurosyphilis: A Negative Report. (Recently submitted for publication.)
15. Kaplan, L. I.; Read, H. S., and Becker, F. T.: The Action of Thio-Bismol in Quartan Malaria. (In preparation.)
16. Read, H. S.; Kaplan, L. I., and Becker, F. T.: Therapeutic Malaria in Asymptomatic Neurosyphilis: A Comparative Study of Results Following the Use of Malaria and Mapharsen, Malaria and Penicillin, and Malaria without Chemotherapy. Preliminary Report. (In preparation.)

appointed, upon analysis of 32 patients on whom we used this type of inoculation, to find that six were unsuccessful, representing more than a 20 per cent technical failure, since all were successfully reinoculated intravenously. The blood may be taken directly from the donor, and given immediately without delay to the recipient, or oxalated or defibrinated blood may be stored and shipped across the continent in a vacuum bottle with dry ice. It may even be drawn one day, kept in an ordinary refrigerator overnight, and used the next day without any unusual refrigeration precaution and still be infective. Blood may be given intracutaneously, subcutaneously, intravenously, or intramuscularly. Typing of the blood is not required unless more than 10 cc. are given, which in our experience has never been necessary.

The incubation period of therapeutic malaria is variable, from 7 to 14 days in Vivax and 7 to 30 in Quartan. The clinical course is unpredictable. Seldom is the textbook type of febrile episode experienced. Most of the patients experience a little headache, general malaise and nausea for a few days, before they actually demonstrate any febrile response. Following inoculation, the temperature should be routinely recorded four hourly, but during the paroxysms it should be taken every hour to determine the peak. To be considered therapeutically effective, a paroxysm should reach a temperature of 104°. The initial elevation of temperature may be of a remittent type for a number of days until it settles down into the cyclic rhythm. Patients may approach exhaustion any time during the therapy before the optimum amount of fever is obtained. Physical activity is to be encouraged between paroxysms. Aspirin must never be given for comfort. They may be given some rest by the administration of thio-bismol.[17] Thio-bismol may at times help to knock out a weak brood of parasites which is giving an annoying but therapeutically inadequate fever between the regular cycles.

During the course of the therapy, the hemoglobin is checked twice weekly and the red and white blood cells on indication. The icteric index is repeated only if jaundice becomes notable, and serum proteins only if edema is serious. They are taken before inoculation as a base line for comparison with subsequent ones. The spleen and liver are palpated frequently, and the weight is recorded weekly. We do not give sodium chloride perorally during the therapy as has been recommended by some, because it has caused vomiting in a distressing number of patients. We are insistent that the patient get a high carbohydrate, high protein and high vitamin diet. Various protein cocktails, including Amigen, Aminoids and Brewer's yeast, provide the increased protein intake and supplementary vitamins. We have described the advantages of intravenous glucose as a prophylactic agent against liver damage.

The optimum number of paroxysms in therapeutic malaria is debatable, but 8 to 12 seem to have majority support. Our experience with paroxysms is shown in Table II.

TABLE II

No. of Paroxysms Completed	No. of Patients	No. of Paroxysms Completed	No. of Patients	No. of Paroxysms Completed	No. of Patients
2	1	12	16	21	27
3	1	13	14	22	11
4	1	14	25	23	11
5	2	15	12	24	8
6	4	16	25	25	5
8	14	17	17	26	4
9	16	18	14	27	1
10	20	19	17	28	1
11	11	20	21	29	2

We have previously given mapharsen 0.06 grams daily for 10 days, *following* the termination of the paroxysms of fever, but it has

17. Young, M. D.; McLendon, S. B., and Smarr, R. G.: The Selective Action of Thio-Bismol on Induced Malaria. J. A. M. A. 122:492, 1943.

been discontinued at the present time and instead we are giving penicillin, 30,000 units every three hours for a total of 3,600,000 units *during* active malaria. It is started, in the case of Vivax, after the patient attains a fever of 102° and is kept up continuously day and night for 15 days. In the patients receiving Quartan malaria, it is not given until the patient experiences a second paryoxysm because the first paroxysm in so many of these patients has turned out to be abortive and they would be receiving their penicillin without any simultaneous malarial clinical activity. After two paroxysms of Quartan, one can expect to get a satisfactory number of paroxysms and as the interval between the paroxysms is greater, the elapsed time of the malaria activity is sufficient for the administration of the penicillin.

In the frequent and prolonged administration of penicillin intramuscularly, it is important to remember the little points of comfort to the patient. We select four areas and number them as follows: right buttock—1, left buttock—2, right upper arm—3, left upper arm—4, and a chart is made out with the area to be used and the time the dosage is to be given, so that even changing nurses cannot fail to comply. Penicillin is given in a concentration of 20,000 units per cc.

Quinine or atabrine is used to sterilize the blood after the patient has had a sufficient number of paroxysms or if the complications warrant termination. A hemoglobin of 7 grams or a red blood cell count of 2,000,000 are also criteria for interruption of malaria.

The usual clinical features of malaria, anemia, lowered blood pressure, herpes simplex, gastrointestinal distress, muscular pain, cough and weight loss, are not considered complications because of their relative benignity and constancy of appearance during the active febrile disease. The other clinical features in

TABLE III

Incidence of Complications Related to Time of Onset †

Complications		IP	Paroxysms 1-10	Paroxysms 11-25	Con	Total by Species	Sum Total	% of Total Series
Jaundice	V	—	7	11	—	18		
	Q	1	3	—	—	4	22	7.3
Edema	V	—	2	10	1	13		
	Q	—	3	4	1	8	21	7.0
Albuminuria and Hematuria	V	1	20	7	—	28		
	Q	1	15	4	—	20	48	16.0
Acute Nephritis	V	—	1	—	—	1		
	Q	—	2	—	1	3	4	1.3
Neuritis & Neuralgia	V	—	3	3	1	7		
	Q	—	1	1	1	3	10	3.3
Respiratory Distress	V	—	6	3	—	9		
	Q	—	4	—	—	4	13	4.3
Pneumonitis	V	1	—	1	1	3		
	Q	—	—	—	—	0	3	1.0
Perisplenitis (& Splenic Rupture)	V	—	2	2	1	5		
	Q	—	—	1	—	1	6	2.0
Herpes Zoster Ophthalmos	V	—	—	—	—	0		
	Q	—	1	—	—	1	1	0.3
Hemorrhagic Episodes	V	—	3	3	—	6		
	Q	—	3	—	—	3	9	3.0
Miscellaneous*	V	—	8	3	3	14		
	Q	—	4	—	—	4	18	6.0

Total Number Treated Cases Completed—300
Vivax 211
Quartan 89

Key:

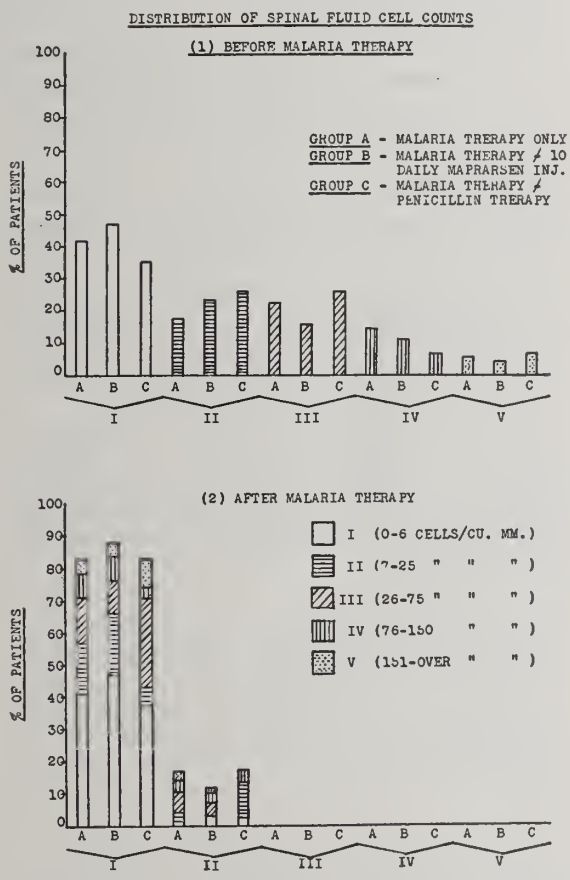
† Complications do not correspond to number of patients, multiple complications occurring in several instances.

* Includes tabetic crises (6); mental complications (5); urticaria (2); hyperlipemia (1); auricular fibrillation (1); convulsive seizures (2); hypocalcemic tetany (1).

IP—Incubation Period. Con—Convalescence. V—Vivax. Q—Quartan.

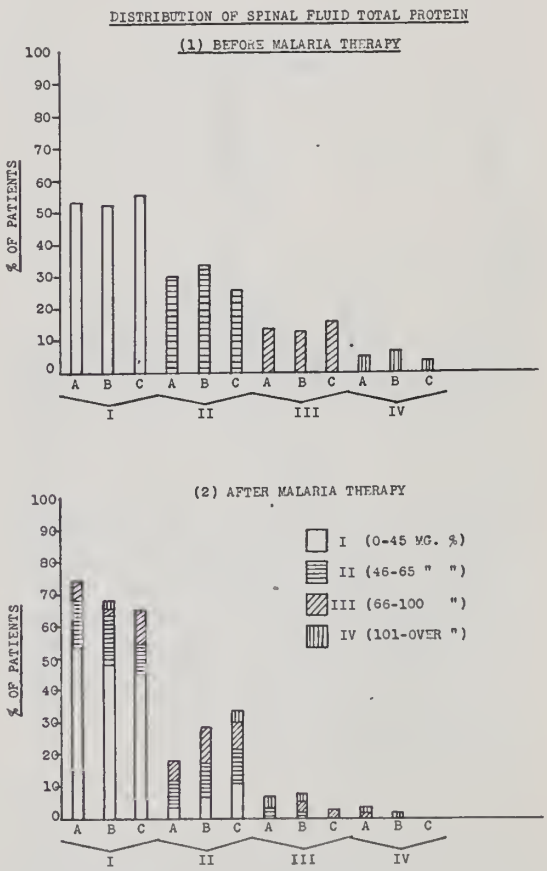
a series of 211 Vivax and 89 Quartan inoculations are listed as complications in Table III, by incidence and time of onset. The latter is indicated in an effort to estimate roughly whether more severe or a greater number of complications followed prolonged malaria therapy, that is, more than 10 paroxysms.

Graphs I, II and III depict the preliminary results of treatment on the spinal fluid constituents in a group of 252 cases of Asymptomatic Neurosyphilis. This series of patients was divided into three groups: Group A received malaria therapy without chemotherapy prior to the post-treatment spinal fluid examination three weeks following the termination of fever; Group B received malaria therapy followed by 10 daily injections of mapharsen prior to the repeat spinal fluid examination; and Group C received malaria therapy simultaneously with the administration of 3,600,000 units of penicillin intramuscularly. A detailed report of the preliminary results in this comparative study is in preparation.[16] Six-month, two-year, and five-year follow-ups in this se-



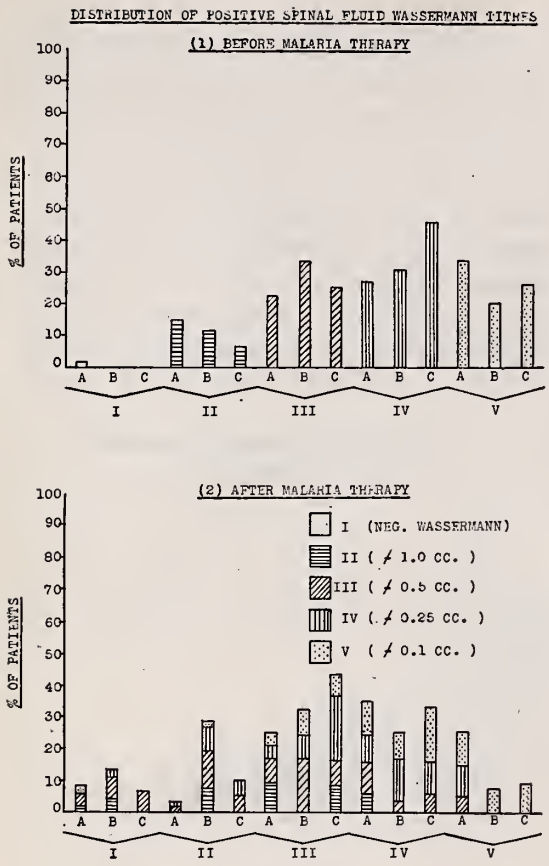
GRAPH I

In Subgraph (1), the legend denotes the three groups of patients compared in this study. Group A consisted of 106 patients; Group B, 98 patients; and Group C, 51 patients. In Subgraph (2), the legend denotes the cell count abnormalities prior to therapy. (E.G.—In A, Group I, in which malaria therapy only was administered, 83 per cent of the patients had normal cell counts [0-6] after treatment, of which 16 per cent had previously had abnormalities in Group II; 17 per cent in Group III; 7 per cent in Group IV; and 3 per cent in Group V. Improvement is thus indicated.)



GRAPH II

Legend for Subgraph (1) as in Graph I. In Subgraph (2), the legend denotes the abnormal increases in total protein prior to therapy. (E.G.—In A, Group I, in which malaria therapy only was administered, 73 per cent of the patients had normal total proteins [0-45] after treatment, of which 17 per cent had previously been in Group II, and 5 per cent in Group III. Improvement is thus indicated.)



GRAPH III

Legend for Subgraph (1) as in Graph I. In Subgraph (2), the legend denotes the degree of positivity of the spinal fluid Wassermann test prior to therapy. (E. G.—In A, Group I, in which malaria therapy only was administered, 8 per cent of the patients had negative Wassermann tests after treatment, of which 2 per cent had previously been in Group II [+1.0 cc.]; 4 per cent in Group III [+0.5 cc.]; and 2 per cent in Group V [+0.1 cc.]. Improvement is thus indicated.)

ries of Asymptomatic Neurosyphilis are contemplated.

(See attached Graphs I, II and III.)

The merit of therapeutic malaria in the treatment of neurosyphilis is well established. Whether or not penicillin will augment or supplant it, only time can prove.

SUMMARY

1. The diagnosis of neurosyphilis and the technique of its management with therapeutic malaria are discussed.

2. Quantitative parasite counts are informative, and essential to well-controlled therapy.

3. The method of inoculation and the parasite dosage influence the malarial course.

4. Mapharsen at the termination of malaria therapy, or penicillin during the febrile course, are useful chemotherapeutic adjuncts.

5. Asymptomatic neurosyphilis, Group III, and symptomatic parenchymatous neurosyphilis, in the absence of contraindications, should be treated with therapeutic malaria.

6. Acute syphilitic meningitis, meningovascular, and vascular neurosyphilis should be treated with malaria only if no improvement follows a course of six months to one year of chemotherapy.

The authors wish to express their indebtedness to Mrs. Winifred W. Eickstaedt, Mrs. Ouida M. Turner, Sgt. Ivan G. Strickler, Sgt. Wexford O. Karr, and Cpl. Richard P. Roy for secretarial and technical assistance in the preparation of this report.

"THE AVAILABILITY OF ADEQUATE MEDICAL care!" A mouth-filling phrase that's hard to talk about. At least it's hard for doctors to talk about it, because of the profession's preference for tangible, clearly definable concepts. Take that first word, for instance—"Available". When is medical care available? Thinking in common-sense terms, most of us would say that it's available when a good doctor can reach a patient in time to save life, relieve pain or prevent a complication. With a universal network of hard-surfaced roads and with increasing tendency of state, county and municipal institutions to whizz their ambulances to any corner of their jurisdiction, few Americans are remote from medical care. To many casual observers, however, available care means having a doctor on every block, and pin-rashed maps can be posted showing large areas in the country apparently devoid of any medical office. That many of these areas are deserts, forests, or unpopulated acreage doesn't appear from the map, which reformers want covered with pin-heads like comedones on a nose. Next time anyone spouts about "availability", he ought to be pinned down to a definition and then asked for a geographic bill of particulars. And let it be remembered that 30 years ago there were proportionately more physicians in the country than there are today. Yet medical care is obviously "more available" in 1946 than it was in 1916. The reason of course is that modern methods of transportation have given the doctor a wider service area.

CLINICAL EXPERIENCES IN THE TREATMENT OF LOW BACK AND SCIATIC PAIN ASSOCIATED WITH DISORDERS OF THE INTERVERTEBRAL DISC *

Henry Briggs, M.D., and Sidney Keats, M.D., East Orange, N. J.

For many years the problem of low back and sciatic pain has been studied with considerable interest. Orthopaedic surgeons have now recognized that, in the majority of cases, the cause of this common disability is mechanical in nature. In the past decade since 1934, when Mixter and Barr first reported their experiences with ruptured intervertebral discs with involvement of the spinal canal, the attention of all orthopaedic surgeons has been directed at one of the commonest mechanical derangements causing low back pain and sciatica, namely, disturbances involving the intervertebral disc. The authors have had an unusual opportunity to study this problem and wish to report their clinical experiences in the handling of this rather complex syndrome.

THE ANATOMY OF THE INTERVERTEBRAL DISC

The disc is a highly specialized organ which functions as a cushion between the adjacent vertebral bodies. There are twenty-three intervertebral discs in the normal vertebral column. The structure of all the discs is essentially the same. Each disc is composed of three distinct parts.

1. Cartilaginous Plate: These are thin plates of typical hyaline cartilage which cover the bone of the body of the vertebra and limit the disc proper above and below.

2. Annulus Fibrosus: This fibrous mass arises from the plates, encloses the nucleus pulposus, and inserts into the bodies of the vertebrae and into the anterior and posterior longitudinal ligaments. It molds the size and shape of the disc and gives it the great part of its strength and tenacity. It bears the strain of torsion and extension of the vertebrae.

3. Nucleus Pulposus: This is the semigelatinous core of the disc and is contained within the fibrocartilaginous envelope of the annulus fibrosus. It is the dynamic portion of the disc and bears almost entirely the vertical or weight-bearing shock.

PATHOLOGY

A considerable part of our knowledge of the pathology of the intervertebral disc in the past has been gathered from studies of this structure made at autopsy. We have made careful observations of the pathology of the disc at operation. These may be divided into three groups.

The first group concerns disorders obviously involving the nucleus pulposus. This central core of the disc in youth is a firm, elastic mass, compressible and resilient, and quite difficult to remove because of its tenacity. A normal healthy nucleus rarely will herniate through the annulus which encloses it. A degenerated nucleus will, however, extrude. It is common knowledge that the earliest degenerative changes in the intervertebral disc appear in the nucleus; it loses its fluidity and then is replaced by an inelastic fibrous mass exhibiting no resiliency. Later the annulus undergoes similar degenerative changes, as a result of which the entire disc is thin and loses its elasticity. We do not ourselves know the pathological sequence that brings about this degeneration, but we can speculate that it occurs through a normal aging process beginning in the years of greatest physical activity and supplemented by repeated traumata. The so-called hypertrophic arthritis of the spine, shown as marginal lipping of the bodies of the vertebrae by the roentgenogram, is but a manifestation of nature's attempt to prevent the collapse of the entire disc due to alteration of the nucleus pulposus. One can only hazard a guess why this

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occurs in some and practically never in others. Its prevalence in laborers is common knowledge, leading us to believe that the trauma of repeated heavy lifting is probably one of the chief etiological factors. Whatever the cause of the process may be, it is only the degenerated nucleus that ruptures through the annulus fibrosus to produce the common symptoms of back pain and sciatica. At operation we have found four distinct processes involving the degenerated nucleus pulposus.

The altered nucleus may rupture through a defect in the annulus fibrosus and the posterior longitudinal ligament, extruding small fragments of the inner lamellae of the annulus with it, and lie as a prominent fibrous mass in the spinal canal. This may be lifted out in one piece at operation by simply seizing it with a pituitary rongeur. This condition is not common. Secondly, the nucleus, if very soft, oozes out through a vent in the annulus and then flattens out under the dura in fragments, and migrates. On one occasion we discovered such a flattened mass under the fifth or lumbosacral disc, having migrated from the fourth disc on the ipsilateral side. We have on other occasions picked out small fragments of nuclear material, so degenerated and flattened that its presence could neither be felt with an instrument nor the gloved finger, but appearing in small isolated masses during the exploration of the fourth and fifth intervertebral spaces in cases of low back and sciatic pain. This type of extruded nucleus poses a difficult technical problem for the operator.

The commonest nuclear protrusion is that which passes through the annulus but is still confined by the posterior longitudinal ligament. The herniation in these cases varies in degree from a large mass almost blocking the spinal canal and very easy to locate, to small tumors lying beneath the articular facet and compressing the nerve root in the intervertebral foramen. These can only be located and identified by a foraminotomy (unroofing the foramen), previously described by the senior author. Rather infrequently, we find a rent in the annulus and the posterior longitudinal ligament, and no evidence of the extruded nucleus, but a small piece of detached lamellae of the annulus which hardly at the moment seems sufficient to cause the disability previously noted. In these cases, we feel that the nucleus has been displaced from between the bodies of the vertebrae and has slipped back again within the confines of the annulus, probably during the positioning of the patient on the operating table and during the course of the anaesthesia. The latter findings may explain the occasional "cures" of sciatica following manipulative therapy. Another observation related to the nucleus is the so-called "concealed disc". This condition may be noted at operation when the disc is completely exposed and appears bluish. On palpation the disc is very soft and the point of a hemostat can be pushed into it with ease. The annulus, thinned out posteriorly and laterally, appears degenerated and reflects a similar process in the nucleus pulposus. It is our belief that this process may cause symptoms by ballooning out on weight bearing and lifting, and compressing a nerve root. On several occasions, we have removed degenerated material from such an intervertebral disc.

The second pathological condition of the disc found at operation is what appears to be a general displacement of the disc as a whole. This process has been noted in the young individual who gives a clear-cut history of lifting a heavy object and develops typical low back and sciatic pain. Again the exact mechanism of this process is not clear, but we can only speculate that the attachments of the annulus must give way in order to allow the disc proper to displace posteriorly. Anatomically all of the lower lumbar intervertebral discs bulge to a certain degree in young individuals, but we have noted a very definite excessive bulging of the disc in those cases which have been relieved of their pain by removal of the protruding area followed by a fusion of the involved segments. We have been unable to find degenerated material in any of these discs.

The third group of pathological conditions noted is that of outward bulging of the disc in the older patient. This is usually associated with marginal hypertrophic lipping of the adjacent vertebral bodies. This is a rather common finding and usually noted at the lumbosacral space, associated on the roentgenogram

with a narrowing of this space and sometimes with a posterior displacement of the fifth lumbar vertebra on the sacrum. At operation we have noted that the bulge of the disc is more firm and the bony lipping more extensive than the x-ray indicates. It appears that the annulus fibrosus in these cases undergoes degenerative changes which are at first cartilaginous in nature and then are followed by the deposition of calcium salts at the base of the cartilaginous rim. This protrusion appears to traumatize the nerve roots by two mechanisms noted at operation. At the fifth lumbar interspace this firm, bulging mass compresses the first sacral nerve root against the thickened ligamentum flavum. This protrusion alone or in combination with the thickened ligament causes compression of the nerve root directly or puts the root on stretch, both producing sciatic pain. We have seen similar pathology at the fourth intervertebral space on several occasions. The protrusion of the disc also involves the nerve roots at the intervertebral foramen. Here the combination of the protruding disc, the thickened degenerated annulus and the subsequent calcification diminish the lumen of the intervertebral canal. With the collapse of the degenerated disc, the pedicles are approximated above to the ones below. The cartilaginous surface of the articular facets fibrillate, causing hypertrophic lipping along the posterior margins of the articular processes, and likewise diminishing the diameter of the intervertebral foramen. This gradual obliteration of the intervertebral canal compresses the nerve root as it lies in the space, producing severe sciatic pain. This type of root compression is common to the lower lumbar and cervical roots, but has been seen throughout the spine. Roentgenograms, we wish to stress, do not fully reveal the degree of foraminal compression, especially in the cervical area, noted at operation.

CLASSIFICATION OF PATIENTS

We have been able to classify patients presenting the syndrome of low back and sciatic pain into rather definite groups. The first group to consider are those individuals who appear with the typical findings of nerve root pressure and severe intractable pain. This pain is continuous day and night, and even difficult to control with opiates. It is accentuated by coughing, sneezing, and jugular compression. The patient usually presents a list of the trunk, a markedly positive straight leg-raising test with reproduction of the radiating pain on passive dorsiflexion of the foot. There is usually a diminution or absence of the knee or ankle jerk response. These clinical observations are so typically diagnostic and the pain so severe that operation is at once recommended. We have invariably found a large herniation of the nucleus pulposus upon exploration. The primary factor that marks this group is the severity of the pain. In the older patient a collapsed fifth lumbar disc with nerve root pressure will produce pain of equal intensity.

A second group of patients are those having clinical findings of nerve root pressure, but whose pain is not quite so intense. This group may be handled differently depending on various factors. More than once have we seen patients with such typical findings, including a diminished ankle jerk response, when examined at a later date, are practically symptom free and have normal reflex responses. Experience has proven that the deciding factor as to the treatment in this group is the duration of symptoms and the economic problems involved. If time and expense do not have to be considered, conservative treatment should be considered. If the patient does not wish to temporize, operation should be undertaken. In any event we feel that it is the patient's responsibility to make the decision. We can only speculate as to why the classical picture of nerve root pressure can completely disappear. There may be, no doubt, a protrusion of disc material, annulus, nucleus, or both, which either recedes spontaneously leaving a minimal scar, or the inflammatory edema of the root, wrought by the compression of the protruding mass, voluntarily subsides.

The next group, without doubt the largest, complains of backache, and pain referred to the gluteal area on one or both sides, to the posterior sacro-iliac area, to the thighs and sometimes to the lower leg. This group is characterized by not having pain of such dura-

tion to warrant operation, or who rebel at the suggestion of operation because of the minimal amount of discomfort. Clinically, their findings vary from minimal to conclusive evidence of nerve root pressure. There is without question some of the more uncommon disorders of the disc involved.

The group that we are most concerned with is comprised of those cases that give a history of sufficient discomfort to warrant operative intervention, and are agreeable to surgery for the relief of their discomfort, but who do not reveal sufficient evidence to adequately localize their pathology. We are extremely interested in this group because there are technical limits to what we can explore at operation. Ordinarily, it is almost always possible to thoroughly explore the fourth and fifth discs laterally to the entrance of the roots into the foramen at one operation by a technique described by the senior author. At present we are developing a technique of exploring the foramen without foramenotomy but it has not been as yet perfected. What we want to know in this group is whether the lesion is in the foramen, or above or below the fourth disc in the spinal canal. To localize our lesion clinically we have come to rely on the loss of the ankle or knee jerk response. Occasionally definite sensory impairment to pin prick in dermatome patterns will aid in the localization of the pathology. However, in our experience, sensory phenomena have not proven to be characteristic. Paravertebral novocaine injection of the different roots before operation occasionally aids in the localization of the lesion. We have used myelography for localization, preferring Pantopaque to lipiodol. We have long since discarded the use of air myelography. Myelography will only help us in differentiating lesions in the spinal canal; it will not help us in localizing foraminal pathology. Novocaine injection, oblique x-rays, and experience have been our guides in the past. Experience has demonstrated that about 90 per cent of the disc lesions are at the fourth or fifth lumbar levels. When we can adequately explore the foramina at these levels at operation, our problem in this group will be nearly solved. We are making strides in this direction by inserting calibrated catheters into the foramen at operation. Whether the latter technique will solve the problem only time and experience will disclose.

TREATMENT

The methods of treatment for alleviation of low back and sciatic pain are governed by factors already described. The treatment of this common disability has made great progress since surgical efforts have been directed at the sources of the patho-physiological disturbances. Over a period of several years we have used many methods of conservative or non-operative treatment. These include back braces, physiotherapy utilizing the media of infra-red and diathermy, corrective arch supports, lifts under the heels, the application of plaster jackets in the forward-flexed position, manipulation, and traction in recumbency. We have manipulated backs with and without local procain infiltration or under general anesthesia, with or without the application of a plaster jacket. Occasionally manipulation and stretching under anaesthesia has resulted in a peroneal nerve palsy due to further protrusion of the herniating mass. Injection of the nerve roots with procaine and pure ethyl alcohol may lead to disaster at times. The most universally satisfactory method of conservative treatment in our hands has been traction applied to both lower extremities with the patient in a recumbent position on a hard mattress, the so-called double Buck's extension. According to the pathology noted at operation, the latter method seems to be the soundest treatment in the nonoperative cases. We know that disc symtoms are intermittent in nature. Disappearance of symptoms is probably due to a retrogression of the nucleus into the confines of the annulus fibrosus, or release of the scar contracture of the nerve roots produced by the impinging mass, or due to a spontaneous abatement of the inflammatory edema of the root when the threatening mass of the disc retracts. Recumbency and traction definitely assists any of these mechanisms. When the acute symptoms subside, a back support in the form of a flexion jacket or brace is applied.

The operative treatment of disc pathology presents varied and complex problems. The

acute, routine herniated nucleus pulposus seldom offers any particular difficulty for almost always the disc pathology is quickly located and easily removed. The operative technique involved has been adequately described. The most difficult problems arise in the last group of cases noted, that is, those patients that have enough pain to warrant operation yet in whom the clinical findings are not typical. Frequently we explore the fourth and fifth levels and find nothing to explain the symptoms, no nerve root pressure within the spinal canal itself and no concealed disc. It then becomes necessary to explore the foramen. A foramen may be explored by cutting away the overhang of the articular process and exposing the ostium of the foraminal canal. We do not hesitate to do this at either the fourth or fifth lumbar spaces. The latter does not always reveal sufficient pathology to account for the symptoms.

We have frequently found root pressure within the foraminal canal and beyond. Adequate calibration of the foramina will materially aid in the exploration. At present we probe the foramen with calibrated catheters and if there is evidence of constriction of the lumen at the fourth space, we unroof the fourth foramen. If we do not feel by catheterization that the fourth foramen is involved, we unroof the lumbosacral foramen. By this technique we have often found sufficient pathology to account for the symptoms and have relieved the intractable pain. When it is observed that the nerve root compression is caused by collapse of the disc space and subsequent approximation of the pedicles, we gouge out the portion of the pedicles involved and perform a complete foraminotomy.

Following all operations for the relief of disc pathology and the foraminotomies, we complete the operation with a chip fusion. The necessity for doing a spine fusion after a foraminotomy is primarily to stabilize the segments of the spine involved in the removal of the articular facet. It is because we feel that it is imperative to fuse following foraminotomy that we are often hesitant to unroof both the fourth and fifth foramina in exploration. We prefer not to be in the position of having to fuse the fourth vertebra to the fifth after exploring the fourth foramen and not finding pathology there. First of all, it would needlessly stiffen one segment of the spine, and, secondly, it is certainly more difficult to obtain a solid fusion from the fourth lumbar to the sacrum than a simple lumbosacral fusion.

Fusion following removal of a herniated disc mass is necessary to also prevent a later collapse of the disc with subsequent compression of the nerve roots by the adjacent pedicles. We have seen this happen seven years after the removal of a nucleus pulposus without a fusion. We believe that with a solid fusion, our cases will not show collapse to the extent where surgery will again be necessary, and to date we have not seen that happen in any of our cases, some of which are now more than six years without pain. When a nucleus has ruptured, too, the function of the disc, its resilience and mobility, disappear, and the body will attempt to protect the segment by hypertrophic productive changes. This lipping along the margins of the articular processes encroaches on the foramen and compresses the nerve roots. Careful follow-up studies demonstrate that a fusion will prevent this process.

We have also observed slight diminution in the disc space due to collapse, with the superior articular processes digging into the pedicle base of the inferior processes and the foramen underneath roomy with no prior evidence of root pressure from the disc. This bony encroachment seems to be the cause of the pain. Fusion will prevent this type of late disturbance. Whether assymetrical facets are the cause of pain we are not prepared to say. It has been considered so by others for several years, and is now sometimes considered a factor in producing disturbances of the discs. The same is true of the so-called "acute lumbosacral angle". When either condition is present at the fifth lumbar level, it seems logical to us to perform a fusion following exploration of the spinal canal. Although we make every effort to remove all nuclear material possible in a degenerated disc, to prevent herniation of more material, we can never be certain that all the nuclear material has been cleared out from the intervertebral space. In addition, we are likely to remove only the degenerated

nuclear parts. Perhaps at a later date, more of this nuclear mass may degenerate and be extruded. Fusion will certainly aid in preventing degeneration and herniation of the residual nuclear material.

We have presented our views with regard to the necessity of fusing the spinal segments explored in the lower lumbar vertebrae. When one considers that, when the fifth lumbar vertebra is fused to the sacrum, only an expert can discern any loss of motion on examination, there can be no argument against the performance of a lumbosacral fusion following exploration. The same can be said of fusion between the fourth and fifth vertebrae. However, when the fusion is carried from the fourth vertebra to the sacrum, we have noted a lack of mobility, although there is practically no interference with physical activity of the patient. Therefore, we do not advocate such a fusion without due consideration.

Furthermore, spine fusion does not necessarily entail an additional period of recumbency postoperatively. Formerly, we kept our patients in a recumbent position in bed with a low back brace for six weeks postoperatively. At the present time, we frequently apply no brace until the patient is ready to start weight bearing. In selected cases of fourth to fifth lumbar, or lumbosacral fusion, we often use no supporting brace at all in the postoperative period, but we do insist on a low back brace for fourth lumbar to sacral fusion. Recently we have kept these patients in the hospital no more than two weeks, and some have been started on weight bearing at the end of four to ten days.

SUMMARY AND CONCLUSIONS

Disturbances of the lumbar intervertebral discs are among the most common mechanical derangements of the back producing low back and sciatic pain. The problems concerned in the treatment of this rather complex syndrome have been presented. Studies of the pathology encountered at operation have been summarized. These have been discussed in three groups: Disorders of the discs involving the nucleus pulposus, general displacements of the disc as a whole, and protuberance of the discs in the older patient. Patients presenting low back and sciatic pain may be considered under four separate classifications: those individuals who present the typical clinical findings of nerve root pressure with intractable pain, those patients having the clinical findings of nerve root pressure without intense pain, those with referred pain of insufficient duration to warrant operation, and that bizarre group who give sufficient pain to warrant operative intervention but who do not reveal sufficient findings to adequately localize the lesion. We are most concerned with this latter group who are usually explored at the fourth and the fifth lumbar levels, and calibrated catheters inserted into the intervertebral foramen, followed by foraminotomy and fusion of the involved segments.

The treatment of patients presenting low back and sciatic pain associated with disorders of the intervertebral disc may be divided into conservative and operative measures. Recumbency in traction followed by plaster jacket or brace support is recommended as the most satisfactory conservative method. Operative measures include exploration of the spinal canal for gross herniations of the nucleus pulposus with removal of the tumor mass, exploratory foraminotomies, and chip fusion of the involved segments. Fusion is recommended following all explorations of the lumbar spinal canal and the adjacent intervertebral foramen. Calibration of the intervertebral foramen by the use of catheters has been described and the results thereof will be presented at a later date.

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STATE ACTIVITIES

TRUSTEES' MEETING

A special meeting of the Board of Trustees was held at the Executive Offices, Trenton, at 2:00 p. m., Sunday, December 16, 1945.

Those present were: Dr. Norton, Chairman, who presided; Dr. Schaaf, Dr. Alexander, Dr. Costello, Dr. Londrigan, Dr. Hawkes, Dr. Fithian, Dr. North and Dr. Hornberger. Also present upon invitation were Dr. Lewis, Dr. Quigley, Dr. Sica, Dr. Johnsen, Dr. Donohoe and Dr. Snedecor.

MEDICAL CARE OF THE VETERAN

Dr. Schaaf presented the report of the Veterans Liaison Committee. See page 20, this *Journal,* for full report.

CANCER SURVEY OFFICE

Communications were read from Dr. Floyd E. Keir, Chairman of the Cancer Control Committee, and Dr. Emil Frankel requesting temporary office space, telephone and a typewriter in the Home of The Medical Society of New Jersey for purposes of conducting a survey of cancer treatment facilities in New Jersey. The survey, which was suggested by the Cancer Committee of the State Society, will be financed by the American Cancer Society, New Jersey Division.

Upon motion the above request was tabled until the January 27th meeting of the Board of Trustees.

RETURN OF EDITOR

Upon motion, seconded and unanimously carried, Dr. Henry A. Davidson will return as Editor of *The Journal* as soon as available, at the same salary, to be taken from the contingent fund; the date of his return to be determined by the Chairman of the Publication Committee.

RESOLUTION RE NATIONAL PHYSICIANS COMMITTEE

With the unanimous consent of the Trustees the following resolution was presented by Dr. Londrigan:

Whereas, The members of the Board of Trustees of The Medical Society of New Jersey in common with physicians throughout the nation are fully conscious of the progressively effective program of the National Physicians' Committee in its dissemination of factual information on the values, methods, accomplishments, and extension of American medicine, and

Whereas, The public, as a result, has not only been generally enlightened on the contributions, achievements and true aims of the medical profession in these United States, but has also been warned of the dangers to the public health implied in the subtle campaign which would discredit the doctor, therefore be it

Resolved, That the members of the Board of Trustees of The Medical Society of New Jersey hereby affirm their confidence in the National Physicians' Committee, and give their hearty approval and support to its program for the protection of both doctor and patient.

Upon motion, seconded and unanimously carried the above resolution was adopted, and it was directed that a copy be sent to the National Physicians' Committee.

DUES CREDIT FOR DISCHARGED PHYSICIANS

With the unanimous consent of the Trustees the action of May 23, 1945, "That members of the State Society be given a dues credit or remission for the first full year's dues after discharge from service", was discussed, in response to inquiries from County Treasurers as to whether or not this action was retroactive. Upon motion by Dr. Schaaf, seconded and unanimously carried, the Board voted that the action is not retroactive.

CORRESPONDENCE

With the unanimous consent of the Trustees the following item was presented:

Request has been received from the Trenton Chemical Society for meeting room space the first Tuesday evening of each winter month.

Dr. Schaaf moved that the policy of the Society to make meeting room space available only to the allied professions: nursing, dental and pharmaceutical, be reaffirmed. Seconded and unanimously carried.

The meeting was adjourned at 4:15 p. m.

Edith L. Madden,
Secretary Pro Tem.

VETERANS LIAISON COMMITTEE

The Veterans Liaison Committee of the Board of Trustees of The Medical Society of New Jersey met at 11:00 a. m., Sunday, December 16th, 1945, at the office of the Society in Trenton. Present were Dr. E. Zeh Hawkes, Dr. Samuel Alexander and Dr. Royal A. Schaaf, who acted as Chairman in the absence of Dr. Frank G. Scammell who was ill. Dr. Thomas B. Lee was also unable to attend because of illness.

The Committee considered a number of reports and other documents and after considerable discussion the following report and recommendations were approved for presentation to the Board of Trustees:

I. The Committee recommends that the general principles submitted by the New Jersey Delegates to the A. M. A. House of Delegates on December 3, 1945, in Chicago be approved and adopted by the Board of Trustees for The Medical Society of New Jersey as our basic principles.

The Medical Society of New Jersey is of the opinion that organized medicine should concern itself actively with and should assume a large measure of responsibility for the medical care of the returned wounded and physically unfit veterans of our armed forces. It is of the opinion that detailed plans for such care should be established at a county level.

Based on a study of the Monmouth County Plan and numerous other proposed plans, the principles may be stated as follows:

1. That there be established by each county medical society a liaison committee to serve in coöperation with the local representative of the Veterans Administration, with the following duties:

   a. To provide screening or diagnostic teams or clinics in hospitals or other suitable locations for the purpose of establishing the medical needs of the veteran and directing him to the physician or institution where he may be most adequately treated;

   b. To utilize to the fullest extent the channel of the private practice of medicine;

   c. To establish fees for service rendered at the average rates existent in the particular community;

   d. To utilize in cases requiring hospitalization the approved hospitals in the immediate locality, except where state, county or Veterans Administration hospitals are indicated as more suitable for the condition involved;

   e. To obtain, through coöperation with the local representative of the Veterans Administration, the greatest possible simplicity of forms for obtaining authorization and for rendering reports and bills;

   f. To serve as an appeal board to determine adequacy of medical service and to be endowed with disciplinary power over physicians to protect the interests of the veteran and the Veterans Administration.

2. That existing general hospitals be used to the fullest extent in each community with enlargement where necessary by federal grants. The indiscriminate erection of new institutions by the federal government would be wasteful and, in most cases, would remove the veteran far from his home. It is our studied opinion that new institutions should be erected only where need for cases that require long and continued hospitalization or for large groups requiring unique or unusual medical care. The need for such institutions should be clearly demonstrated before establishment.

3. Care at government expense should be limited to veterans who: (a) have service-connected disability, or (b) who are in need economically.

A veteran not suffering from service-connected disability and not in acute economic want should obtain his medical care in the same manner as any self-sustaining citizen.

II. To implement these principles, the Committee recommends that the plan submitted by the Monmouth County Society, as amplified by the recommendations of Essex County, be formally adopted as the established policy by The Medical Society of New Jersey.

MONMOUTH COUNTY PLAN

The Plan is, briefly, as follows: All members of the Monmouth County Medical Society who are willing to serve will be designated as out-patient physicians on a fee basis for the Veterans Administration (this will be approximately 90 per cent of our membership). A committee of the Society will supervise the work to make sure that the veterans are given proper care. In addition, at convenient places, at such intervals as the volume of work requires, there will be screening clinics. These will be staffed by specialists. To these clinics the returning veteran may come, having authorized the Red Cross to obtain his Army medical record. On the basis of this record, and their own findings, the clinic staff will determine whether the veteran needs treatment, and if he does, whether such treatment can be carried out at home or requires hospitalization.

If the condition can be treated on an out-patient basis, the patient will be shown a list of physicians qualified to treat his condition, from which he makes his choice. If he has no choice, he will be assigned to one convenient to his home. The Veterans Administration will provide the necessary clerical work and will provide a liaison officer to authorize the referral. The clinic staff will be paid on a fee basis, or as part-time Veterans Administration physicians.

We expect to correlate the above program with the Veterans Administration plans to use local hospital facilities, both general and specialized. We expect that any veteran in a general hospital would be treated by a designated physician who is also a member of the staff of that hospital. Other arrangements, naturally, would have to be made with specialized hospitals (such as nervous and mental) having full-time closed staffs.

Administrative and other details will have to be worked out. However, any plan adopted should be based on the following principles: Individual, doctor-patient relationship be preserved; free choice of physicians as far as possible; medical and hospital

care within a reasonable distance of the veteran's home; and the principle of fee for service as far as possible.

ESSEX COUNTY RECOMMENDATIONS

It is understood that this program concerns only the care of service-connected or other disabilities now authorized under the G. I. Bill of Rights, and that this care may be rendered to veterans admitted to hospitals for treatment or who receive treatment for eligible conditions in their homes or the offices of private physicians; and that in addition to treatment of the veteran, the program includes diagnostic examinations of veterans referred by the Veterans Administration. Our proposed program is, therefore, divided into two parts: (1) Services rendered in diagnostic clinics and hospitals. (2) Services rendered in the homes of veterans and the offices of physicians.

1. DIAGNOSTIC CLINICS

The Veterans Administration will establish diagnostic clinics by arrangements with local hospitals where technical facilities are available. The Administration will also provide a full or part-time physician selected from a list of local physicians to act as the representative of the Veterans Administration and as administrative officer of the clinics.

The Veterans Administration will determine the eligibility of each veteran to whom service is to be rendered prior to his reporting to the clinic. The Administration will forward to the administrative officer of the clinic in advance each month the names of veterans to be referred to the clinic during that period, stating the type of service required.

The administrative officer of the clinic, representing the Veterans Administration, shall have authority to approve or disapprove requests for auxiliary technical diagnostic procedures submitted by the physicians attending the clinic. He shall also approve for payment the bills for authorized services rendered by each physician serving in the clinic each month and forward bills for such authorized services to the proper office.

FUNCTIONS OF THE VETERANS ADMINISTRATION LIAISON COMMITTEE

It shall be the duty and responsibility of the Veterans Administration Liaison Committee to maintain the adequacy of medical services rendered to the veteran. It shall be the duty and responsibility of the Veterans Administration Liaison Committee of the County Medical Society to select from the list of members of the Society, who have indicated their desire to serve, qualified physicians and specialists to carry out the work of the clinic. Appointment to the clinic to be made by the Veterans Administration.

The Veterans Administration Liaison Committee shall have the duty after thorough review to recommend the termination of the appointment of any physician or specialist who is not rendering satisfactory service. A physician so dismissed shall have the right of appeal to the Veterans Administration.

In cases referred from the clinic to a private physician it shall be the responsibility of the Veterans Administration Liaison Committee to assist the veteran in selecting a physician from the list of designated physicians.

It is understood that in general, three types of cases will be referred to the clinic:

A. Those referred for neuro-psychiatric examination and opinion.

B. Those referred for examination and report regarding degree of disability upon which pension benefits may be determined by the Veterans Administration.

C. Those referred for diagnostic examination and reference to private physicians for definitive care.

2. HOME AND OFFICE CARE OF THE VETERAN

Adequate home and office care of authorized disabilities presents a more difficult administrative problem than do those cases referred for treatment in hospitals. The plan must contain provisions to protect the interests of the government, the veteran, the physicians, and at the same time provide for prompt and adequate medical care.

A. Each veteran shall be furnished with an identification card upon which is stated his service-connected disabilities.

B. In cases appearing at the diagnostic clinic for whom home and office care is recommended by the physicians of the clinic, the administrative office shall authorize necessary medical care. The Veterans Administration Liaison Committee shall review the bill in disputed cases and make appropriate recommendations.

C. When a veteran appears at the office of a physician or calls a physician to his home for care of authorized disability as stated on his card, the physician shall communicate with the nearest office of the Veterans Administration, obtain authority for necessary medical care; this authorization to be later forwarded to the physician by the local office of the Veterans Administration on a proper form; this form to be submitted by the physician with his bill to the Veterans Administration as authority for payment.

D. Disputes between the veteran and the physician or between either and the Veterans Administration will be referred to the Veterans Administration Liaison Committee, which shall have power to take proper action or to make recommendations to the Veterans Administration.

III. The Committee further recommends that every effort be made to arrange with the Veterans Administration for the transaction of the financial aspects of the veteran's care through the Medical Service Administration of New Jersey, as tentatively proposed in the following letter. (This is a letter sent on 16 December 1945 by the Medical-Surgical Plan to the Trustees of the Society.)

Gentlemen:

The United States Veterans Administration proposes that war veterans suffering with "service connected" diseases be cared for by civilian physicians of their own choice;—the eligible services to include medical care rendered in the veteran's home, physician's office and in community hospitals.

It is estimated that there will be 600,000 World War II veterans and 120,000 World War I veterans in New Jersey; of these, about 30 per cent will have service-connected disabilities.

The New Jersey Hospital Association announced that it would recommend that all hospitals in New Jersey participate in the program through contracts with the Veterans Administration providing a per diem rate of $6.00 plus extras in the same manner as they now deal with compensation cases.

Steps are being taken in other states, notably

Michigan and Kansas, to have the voluntary medical service plans organized by those State Medical Societies act as a coördinating and administrative agency of the program at a state level between organized medicine and the Veterans Administration. Such a contract between Michigan Medical Service and the Veterans Administration is now awaiting approval in Washington.

Medical Service Administration of New Jersey is in a position to assume this function if it is the wish of the Society. Such an arrangement has the informal approval of General Hawley, Medical Director of Veterans Administration. The one great advantage of such an arrangement is that it would give both organized medicine and Veterans Administration one administrative agency in each State.

The arrangement would function along the following lines. This outline is in very rough form and sets forth only the desire and intent of such an arrangement.

1. Medical Service Administration through The Medical Society of New Jersey and the County Societies would enlist physicians who would agree to participate and accept as payment in full the fees enumerated in a schedule to be evolved by consultation between the State Society and Veterans Administration. Since General Hawley has stated that he will deal only with members of their respective county medical societies, it is hoped that every member of each Society will participate.

The names of such physicians would be referred to the Veterans Administration for appointment as "designated physicians".

2. A full-time Veterans Administration officer or employee, preferably a physician, would be assigned to the office of Medical Service Administration. He would represent the Veterans Administration and would be empowered to authorize out-patient examinations or treatments. He might be the same physician as proposed in our "principles" to coördinate the activities of the veterans' clinics to be operated on a county basis. The Medical Director of Medical Service Administration would represent organized medicine, particularly through the liaison committees to be organized by each County Society as per the "principles" presented to the American Medical Association House of Delegates, and the liaison committee appointed by your Board of Trustees.

3. Medical Service Administration will make payment to individual physicians for all authorized examinations or treatments in accordance with the fee schedule and will in turn bill Veterans Administration for reimbursement at monthly intervals.

4. For this service Medical Service Administration will be reimbursed the actual cost of the fees disbursed to which will be added an additional amount up to 7 per cent to repay administrative costs.

5. Medical Service Administration will be responsible for a proper set of records which will be available to members of organized medicine or the Veterans Administration at any time. Medical Service Administration will see that reports which may be required by Veterans Administration are in proper form before submission and will undertake to simplify the present forms required of Veterans Administration from physicians.

6. The proposed fee schedule * is for your consideration. It follows the sequence and nomenclature of the schedule submitted by Michigan Medical Service. This was considered desirable to promote uniformity. The fees have been adjusted to what may be considered as modest, reasonable fees pertaining to the State of New Jersey. Further adjustment will undoubtedly be necessary, particularly if local societies insist upon county adjustments. It would be best, however, if the schedule could be adopted to state-wide use rather than to have separate schedules for each county.

If this suggestion is approved by your Board of Trustees, every effort will be made to place the program in operation as soon as possible, but it must be remembered that the matter requires further study and a lot of work to evolve detailed administrative procedures and a contract between Medical Service Administration and Veterans Bureau.

Respectfully submitted,

NORMAN M. SCOTT, M.D.,
Medical Director.

* Fee schedule on file in Executive Offices, 315 West State Street, Trenton.

IV. The Committee also recommends that it be authorized to seek the coöperation of the New Jersey Hospital Association for the purpose of solving problems of mutual concern.

V. The Committee further recommends that it be authorized to seek the coöperation of any member of the Society not now a member of the Committee who may be able to assist it in the development or execution of the plans for veterans' care.

VI. The Committee further recommends that the specialized medical organizations in New Jersey, instead of acting as independent units in this connection, be asked to coöperate with the Medical Society in their dealings with the Veterans Administration.

FRANK G. SCAMMELL, M.D.,
Chairman
ROYAL A. SCHAAF, M.D.
SAMUEL ALEXANDER, M.D.
THOMAS B. LEE, M.D.
E. ZEH HAWKES, M.D.
Veterans Liaison Committee.

Dr. Lewis reviewed the report of the Reference Committee on Care to Veterans which he had presented to the A. M. A. House of Delegates on 4 December 1945. This report was published on pages 1190 and 1197 of the 22 December issue of the *Journal of the American Medical Association*. The final decision of the House of Delegates thereon was summarized by the Reference Committee there as follows:

The Committee therefore recommends:

That the House of Delegates pledge its support to General Hawley in his effort to provide the best medical care under the Veterans Administration.

The Committee was also asked to consider three resolutions all pertaining to the medical care of veterans. Those resolutions presented from New Jersey and Oregon we feel have been fully covered

in principle by the Resolution just considered by the House and need no further action.

Upon motion by Dr. Londrigan, seconded and unanimously carried, the report and recommendations of the Veterans Liaison Committee were approved and the Committee was authorized to present the plan to General Hawley.

At the request of Dr. Johnsen, it was directed that an outline of the plan be prepared for presentation 13 January 1946 to the Welfare Committee meeting on that date.

NUTRITION IN EVERYDAY PRACTICE

S. WILLIAM KALB, M.D., Newark, N. J.

Nutrition Representative, Tuberculosis and Adult Disease Control Advisory Committee to the Subcommittee on Public Health

1. *I have given liver and iron to many anemic patients showing a high color index with poor therapeutic response. Why?* Many of these patients have an associated vitamin C deficiency. Giving 300 mg. of ascorbic acid daily and a large glass of orange juice in the morning will usually help the initial therapy used for the anemia.
2. *Is the hemoglobin in a new born reduced if the pregnant mother is deficient in iron?* The fetus stores many elements taken from the mother and if the mother is deficient in iron, the fetus obviously can't receive very much of this mineral. The fetus may have enough of a reserve so that it can be born with a normal per cent of hemoglobin. However, it may develop a marked anemia during its first year.
3. *What skin diseases respond to vitamin therapy?* The only deficiencies found at present are vitamins A and C. Vitamin A deficiency is found in dermatitis due to drugs and pyoderma. Vitamin C is deficient in urticaria, lupus erythematosus, and pyoderma. Nearly all other skin disorders are found with high or normal vitamin levels except the above-mentioned diseases.
4. *How can a normal water balance be maintained within the colon to help constipation?* The minimal water requirements per day for adults are 1400 cc. Bile influences the amount of water to be absorbed in the colon. Biliary constipation is due to a shortage of secreted bile in the bowel of middle aged persons with sedentary habits. Therefore, whole bile or bile salts should be given to restore the normal mechanism of proper water balance in the colon.
5. *What is the best calcium preparation to prescribe for treatment or prophylaxis in decaying teeth?* Calcium is not the drug of choice. Isolate the tooth to be treated with cotton rolls, dry the tooth with compressed air or a rubber ear syringe. Wet the crown surface of the tooth with 2 per cent Sodium Fluoride solution, then allow it to dry in the air for 4 minutes. Decay is resisted in 40-45 per cent of teeth treated with this topical treatment, while 25 per cent of teeth which are already carious do not decay.
6. *Can harmful effects result from synthetic vitamins?* Data are accumulating to the effect that indiscriminate use of vitamins has serious side reactions. These should be used as dietary supplements and not as drugs in high doses because the potency may cause toxic manifestations. Massive doses of vitamin D used in arthritis may cause renal damage, hypercalcemia, anemia, elevated blood nonprotein nitrogen, and osteoporosis. One must be careful in juggling the vitamins around in a formula. The dosage should conform to the normal amounts found in food and shouldn't drift too far from the daily requirements.
7. *What is the best diet for aged individuals?* A person, after age 35, should follow a low cholesterol diet since cholesterol metabolism ceases after this age. The foods that are low in cholesterol and best for the aged are:

FISH
Bass
Clams
Cod
Flounder
Haddock
Oysters
Perch
Pike
Scallops

VEGETABLES
Asparagus
Carrots
Lettuce
Mushrooms
Potatoes
Spinach
Squash
String beans
Turnips

FRUITS
Apples
Apple sauce
Orange juice
Peaches
Pears
Plums

SOUPS
Gumbo
Ox tail
Tomato
Turtle

MISCELLANEOUS
Corn starch
Rye bread
Skimmed milk
Sugar
Syrup, maple
White bread
White flour

WITH NEW JERSEY MEDICAL AUTHORS

It is requested that any New Jersey physician who publishes an article outside the state, notify the Editorial Office in Trenton, giving the title of the paper and the name of the periodical, as well as the month, date, volume and page number. It would also be helpful to this office if members would notify us of articles published by their colleagues.

ALTER, NICHOLAS M.—see Norton, James F.

BERNHARD, WILLIAM G.—Newark (in service), with others
Prevention of pneumonoccal pneumonia by immunization with specific capsular polysaccharides. J. Exper. Med. 82: 445-465, Dec. '45

FOSTER, J. W.; L. E. MCDANIEL, H. B. WOODRUFF and J. L. STOKES—Rahway (Merck)
Microbiological aspects of penicillin. V. Conidiospore formation in submerged cultures of penicillium notatum. J. Bact. 50: 365-68, Sept. '45

GALLICO, MARGARET WILSON—Vineland (with Nathaniel Warner)
Occurrence of psychoneurotic symptoms on the various services of a naval hospital. 45: 1119-1124, Dec. '45

COPLEMAN, BENJAMIN (in service)
Anomalous right subclavian artery. Am. J. Roentg. 54: 270-275, Sept. '45

COPLEMAN, BENJAMIN
Roentgenologic exploration of sinus and fistulous tracts. Am. J. Surg. 70: 197-200, Nov. '45

GOLDSTEIN, HYMAN I.—Camden
Use of methenamine in dermatology. Arch Derm. & Syph. 52: 185, Sept. '45

JONES, DORIS—New Brunswick (N. J. Agricultural Exper. Station)
Effect of antibiotic substances upon bacteriophage. J. Bact. 50: 341-48, Sept. '45

LARSEN, ALMA—see Stokes, J. L.

MCDANIEL, L. E.—see Foster, J. W.

NICOLA, TOUFICK—Montclair
Atlas of surgical approaches to bones and joints. 1945. Macmillan.

NORTON, JAMES F., and NICHOLAS M. ALTER—Jersey City
Primary ovarian pregnancy. Am. J. Obst. & Gynec. 50: 535-38, Nov. '45

PARSONNET, EUGENE V.—Newark (in service), with J. R. TWISS
Management of peptic ulcer. J. A. M. A. 129: 857-63, Nov. 24, '45

RADOS, ANDREW—Newark
Vitamin C saturation and senile cataract. Arch. Ophthal. 34: 202-209, Sept. '45

SHANE, SYLVAN M.—Camden
Curare—A complement to anesthesia. Anes. & Analg. 24: 256-58, Nov.-Dec. '45

STOKES, J. L., and ALMA LARSEN—Rahway (Merck)
Transformation of the streptococcus lactis R factor to "folic acid" by resting cells suspensions of enterococci. J. Bact. 50: 219-227, Aug. '45

STOKES, J. L.—see Foster, J. W.

WHIMS, C. B.—Ventnor
General manifestations of salicylism. South M. J. 38: 722-26, Nov. '45

WOODRUFF, H. B.—see Foster, J. W.

AMERICAN ACADEMY OF PEDIATRICS

HARROLD A. MURRAY, M.D., Chairman for New Jersey

The Annual Meeting of the New Jersey Fellows of the American Academy of Pediatrics will be held in Newark on January 30, 1946.

The afternoon session will be held at the Academy of Medicine at three o'clock. The titles of the papers to be read at this meeting are:

1. "Roentgen Manifestation of Broncho-Sinus Diseases in Children," by Dr. W. J. Marquis, East Orange, N. J.
2. "The Use of Curare in Poliomyelitis," by Dr. Samuel Blaugrund, Trenton, N. J.
3. "The Use of Large Doses of Vitamin D in Pediatric Practice," by Dr. I. J. Wolf, Paterson, N. J.
4. "Sudden Death in Infancy," by Dr. Harrison S. Martland, Newark, N. J.

Cocktails and dinner will follow at the Essex House at six o'clock with a discussion of the "Child Welfare Services under the Pepper Bill," by Dr. Stanley Nichols, Long Branch, N. J.

In May the Coit Memorial (Babies') Hospital will celebrate its fiftieth anniversary. There will be a meeting on the morning of January 30th at the hospital in tribute to the late Doctor Coit. It will be in the nature of a clinical conference followed by a luncheon. Any members of the profession who are interested are invited to attend.

THE BULLETIN BOARD

Full and free discussion of the Wagner-Murray-Dingell bill is promised at a symposium on January 23, 1946, sponsored by the Union County Medical Society. Physicians are invited to attend this discussion which will start at 9:00 p. m. at the Elks Club, 17 Westfield Avenue, Elizabeth.

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Graduate courses in cardiology begin this month at the Montefiore Hospital, Bronx, N. Y. The courses are given under the direction of Columbia University. For details write to Dean, Faculty of Medicine, 630 West 168th Street, New York City 32.

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A revised supplemental sheet to the current Pharmacopoeia may be obtained by writing to U. S. Pharmacopoeia at 4738 Kingsessing Avenue, Philadelphia 43.

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New Jersey has one of the most favorable infant mortality rates in the U. S. A., according to a recent release of the U. S. Department of Labor. The rate (deaths per thousand live births) was 33 for New Jersey, 40 for the country as a whole. New Jersey is the sixth in infant mortality, best rate being Connecticut's 30. Highest infant mortality is in New Mexico where the rate exceeds 91.

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The American College of Physicians announces a four-day annual meeting in Philadelphia, beginning May 13. For a copy of the program write to E. R. Loveland, Executive Secretary, American College of Physicians, 4200 Pine Street, Philadelphia 4.

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Ophthalmologists are reminded that the next examination of the American Board of Ophthalmology will be held in New York on April 10, and the one after that in San Francisco on June 22.

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Psychiatrists interested in residencies, fellowships or job placements are notified that the American Psychiatric Association and the National Committee for Mental Hygiene now have a jointly operated Personnel Placement Service to facilitate training and relocation. Inquiries should be addressed to Dr. F. M. Harrison, National Committee for Mental Hygiene, 1790 Broadway, New York 19, New York.

* * * * *

Senator Smith of New Jersey was one of a bipartisan group of legislators who introduced JR 89 into the U. S. Senate. This resolution urges the "speedy convening of a conference to establish an international health organization". Such an organization would be expected to collect world-wide health statistics, standardize drugs and consolidate and disseminate medical and health knowledge.

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Hospitals may qualify for the purchase of surplus army or navy medical equipment, often at a discount, by submitting applications to the Federal Security Agency, USPHS, Bethesda Station, Washington 14, D. C.

* * * * *

Two cash prizes are currently announced for medical authors. The Mississippi Valley Medical Society offers $100 for "the best unpublished essay on any subject of general medical interest". Closing date is May 1, 1946, and queries should be sent to Dr. Harold Swanberg, 209 WCU Building, Quincy, Illinois. The best essay "concerning original work on problems related to the thyroid gland" will draw a $300 prize from the American Association for the Study of Goiter. Deadline here is February 20, 1946, and correspondence should go to Dr. T. C. Davison, 207 Doctors Building, Atlanta 3, Georgia.

* * * * *

This month marks the launching of a new medical journal bearing the simple title of *"Blood"*. The periodical will devote itself entirely to diseases of the blood and blood-forming organs. It is expected that six issues a year will be published. Subscriptions ($6 a year) are obtained from Grune and Stratton at 381 Fourth Avenue, New York 16, N. Y., while copy for publication should be sent to Dr. William Dameshek at 25 Bennet Street, Boston.

* * * * *

A 96-page monograph on Sex Endocrinology is available to doctors who write for it to the Schering Corporation, Broad Street, Bloomfield, N. J. The book has a section dealing with the chemistry of the sex steroids and another section on practical therapy.

* * * * *

A handy medical word-book is furnished without charge to doctors by the Birtcher Corporation at 5087 Huntington Drive, Los Angeles 32, California. This booklet will be especially useful to nurses, technicians and office secretaries as it explains the basic meanings of medical prefixes and suffixes and analyzes the structure of medical words.

* * * * *

Pediatricians will be interested in the availability of the child-health film *When Bobby Goes to School*. This is a 16-mm. sound film which may be borrowed by any physician without cost, from Mead Johnson & Company, Evansville, Indiana. Arrangements for procuring the film should be made through your county medical society, since the company requires their endorsement before releasing it to a private practitioner. The medical society obtains "endorsement and approval blanks" direct from Mead Johnson. The film is especially appropriate for exhibition to women's organizations and P.-T. A.'s.

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The next meeting of the Cape May County Medical Society will be held at the Shore Memorial Hospital, Somers Point, N. J., at 9 p. m., Tuesday, January 22, at which time moving sound pictures will be shown by Mr. Leo Green, Atlantic City, on "Inoculation".

COUNTY SOCIETY REPORTS

ATLANTIC COUNTY

Walter B. Stewart, M.D., Reporter

The *Medical Society of Atlantic County* held its monthly meeting on Friday, December 14, 1945, at 9:00 p.m. in the Chelsea Hotel. The guest speaker of the evening was THOMAS A. SHALLOW, M.D., Professor of Surgery, Jefferson Hospital, Philadelphia, whose subject was "The Conservative Management of Acute Pancreatitis." Dr. Shallow was assisted in the presentation by Dr. Wagner, who analyzed 28 cases of acute pancreatitis which have been studied in the last four years at Jefferson Hospital. This condition occurs in middle and later life, equally in the two sexes, and rarely in the colored race. One case occurred at the age of 12 years. Diagnosis is made by means of the serum amylase test. The etiology is still disputed, but in general, cases may be grouped as non-infectious (the larger number) and infectious. The chief causes in the non-infectious group are:

1. Mechanical. The common channel theory, in which obstruction occurs at the ampulla; as by stone, spasm, edema, metaplasia of epithelium of ducts.

2. Chemical. (a) Reflux of bile into pancreatic duct, irritation by the bile salts, with the liberation of trypsin and the resultant auto-digestion. (b) Reflux of duodenal contents. (c) Autolysis of pancreas by own enzymes.

3. Degenerative. Secondary to benign or malignant tumors or secondary to degenerative vascular processes.

4. Trauma. In only two to four per cent of cases.

The infectious group is usually secondary, spread by adjacent lymphatics, especially in chronic cholycystitis (64 per cent of the cases had disease of the biliary tract), by the blood stream, or by the ducts. Among the 28 cases there was only one death, showing fat necrosis of the pericardium and the pleura. There are two types of pancreatitis:

1. Acute edematous pancreatitis. This is the frequent form and is usually mild. The gland is enlarged, hard and rubbery, in one case four times normal size. There is no free fluid in the peritoneal cavity. Areas of fat necrosis are limited to the pancreas.

2. Hemorrhagic pancreatitis. The gland is soft and necrotic. There is free bloody fluid in the peritoneal cavity and there are areas of hemorrhage in the pancreas. The areas of fat necrosis are diffusely scattered.

It is impossible to make a diagnosis on clinical grounds alone.

Acute pancreatitis is a great imitator, the symptoms depending on the area of the pancreas involved, whether the head, body, uncinate process or tail. In any case of acute upper abdominal pain one should always consider acute pancreatitis. The serum amylase test is of value only in the acute phase, seldom after the lapse of three or four days.

If the diagnosis of the usual form of acute edematous pancreatitis has been made, operation should be delayed, for the patient is in potential shock. Conservative treatment is in order. Give nothing by mouth; give nourishment and medication by vein. Use glucose and plasma; amino acids and vitamins B and C. Give penicillin whether infection is present or not. Treat the associated biliary tract involvement. If there is no improvement, surgery may be necessary for pseudocyst formation or suppuration. Finally, send the patient home on a regimen of small, frequent feedings.

If hemorrhagic pancreatitis is diagnosed, the patient should be operated on, putting a Penrose drain in the area of the pancreas, without disturbing the pancreas itself. Anti-tryptic substances are present in the blood and body fluids, to prevent autodigestion of the tissue cells.

The important things to remember are that we must combat toxicity and an altered blood chemistry, and that we must do a serum amylase test in every case.

BURLINGTON COUNTY

T. Bruce Dickson, M.D., Reporter

A regular meeting of the *Burlington County Medical Society* was held at the Riverton Country Club on December 13, 1945.

Guest speaker was DR. GILSON C. ENGEL, Assistant Professor of Surgery in the Graduate School of Medicine, University of Pennsylvania, and Surgeon to the Lankenau Hospital. He spoke on the diagnosis and treatment of carcinoma of the stomach, pointing out that cancer of the stomach is more prevalent than cancer of the uterus and breast combined. Early symptoms of this condition are fatigue, loss of appetite, loss of desire for meat, and indigestion. X-ray aided by gastroscopy is the method of choice in making the diagnosis. If a gastric ulcer is not completely healed after six weeks of medical treatment, laparotomy should be done with appropriate surgical removal. Dr. Engel's talk was augmented by lantern slides. His speech was extremely interesting and well presented. The Society members who were present will have no difficulty in remembering the main points of the talk.

CAMDEN COUNTY

Joseph C. Lovett, M.D., Reporter

The monthly meeting of the *Camden County Medical Society* was held December 4, 1945, at the Camden City Dispensary with DR. HENRY B. DECKER, President, presiding. There were thirty-five members present.

The speaker of the evening was MAJOR R. C. FAGLEY, M.C., A.U.S. Major Fagley explained the Veterans Administration Plan for medical and surgical care of the veteran.

There is a large group of veterans to be taken care of from World Wars I and II. The Plan is for the medical profession to examine and treat these veterans in their own community. Camden has been designated as one of the centers. There will be

three classifications of doctors: (1) A full-time doctor who will work eight hours. (2) A part-time doctor. (3) The designated physician. It is better for the veteran to be treated by the designated physician. The present fees are antiquated. Each Medical Society should make up its list of fees. The veteran should also be hospitalized in his own community. If the hospitals can take care of them, no large central hospital will be built. There should be contracts for all laboratory, x-ray and physiotherapy work. Some full-time physicians will be needed. It is not "Socialized Medicine" when the physician can set his own fee.

Before a patient is treated he must be authorized, i. e. the physician must get an approval from the Veterans Administration. Any condition due to military service will be authorized. Difficulties will arise in deciding whether the condition is really a result of being in the service. At least a provisional diagnosis must be made on the patient when the physician asks for authorization.

Major Fagley then answered questions concerning the Plan.

It was moved and seconded that a committee be appointed to investigate the Plan.

Business meeting: The elected members, Drs. Franz and Bianco, were introduced to the Society. Dr. Vaughn was elected a member.

A certificate was presented by the Society to Dr. Day for his fifty years in practice. Dr. Day responded by giving an enthusiastic and interesting acceptance speech.

There were several members present who have recently been discharged from the service. All were very glad to have them back with us again as they have been missed.

CAPE MAY COUNTY

C. W. Way, M.D., Reporter

A regular meeting of the *Cape May County Medical Society* was held at the Shore Memorial Hospital, Somers Point, at 9:00 p. m., November 13, 1945, with President George M. Brooks presiding.

The regular meeting night of the Society was changed to the fourth Tuesday.

Captain Edward Jennings, M.C., a former member, was reinstated to full membership. There were many applications from new doctors in Cape May County. These were turned over to the Board of Censors.

The guest speaker was Dr. Frank W. Konzelmann, Chief Pathologist at the Atlantic City Hospital. He spoke on "Interpretation of the Blood Picture." Dr. Konzelmann said:

"Modern methods have improved our understanding of significance of hemoglobin levels in the blood. It must be emphasized that a fixed 100 per cent standard is no more conceivable for hemoglobin than it would be for the height of a human being. It varies with age, sex, geographic location, and occupation, and there is often a diurnal variation of as much as 1 gram. Therefore, for its proper interpretation, one should have available (for they are too numerous to keep in mind) the ranges for each age-level and sex. Hemoglobin should be reported in grams and the result obtained referred to the table. It may be easily remembered that the hemoglobin for the normal adult is from 15-17 grams; females have a slightly lower value than males. Hemogobin rises whenever there is considerable loss of body fluid. Rise in hemoglobin often precedes a falling blood pressure in shock. For this and other reasons, to be listed below, every patient who is to be subjected to surgical procedure or to any diagnostic study, should have the benefit of a complete blood count to serve as a base line for future studies in the attempt to evaluate any unexpected changes which may occur in the patient's condition. The red cell also presents changes which are of great diagnostic value. The older methods of estimating cell size and volume, and the hemoglobin content are not sufficienty accurate today. *Mean Corpuscular Volume* indicates diameter as well as the thickness. It is obtained by dividing the hematocrit reading (that is to say the volume of packed cells, read in cubic centimeters in one liter of blood) by the red cell count in millions. The old color index is much more accurately measured by dividing the grams of hemoglobin per liter of blood by the red cell count in millions. These two factors give an accurate measure of the size of the cell as well as its hemoglobin content. The normal Mean Corpuscular Volume is 80-94 cubic microns, and any cell falling below this range constitutes a microcyte and any above this range a macrocyte. Those within the range are normocytes. Microcytic anemia is usually the result of iron deficiency, and in these anemias Mean Corpuscular Hemoglobin is reduced below the range—27-32 micromicrograms. In chronic diseases, such as diabetes, chronic nephritis, the picture is often one of a microcytic anemia with normal hemoglobin content; the Mean Corpuscular Hemoglobin lies between 27 and 32. In those anemias due to deficiency of Castle's Antianemic Principle; that is, pernicious anemia and similar anemias, the Mean Corpuscular Volume is above the normal range and Mean Corpuscular Hemoglobin is likewise high. These so-called Hyperchromic macrocytic anemias usually respond to liver therapy.

"The leucocyte picture is a helpful one in the study of acute infections. It was long ago pointed out that the evidence of maturation of neutrophile leucocytes lies in segmentation of the nucleus. In the very young neutrophile, the myelocyte, the nucleus is completely round. As it ages, indentation of the nucleus occurs, which in its first stage is characteristic of the so-called juvenile leucocyte, and a little later the nucleus resembles a bent sausage or rod or ribbon. In this stage it is called Stab, and then as the indentation becomes complete, it divides the nucleus into separate masses; the leucocyte is said to be in the segmenter stage. The segmenter is also spoken of as a filament leucocyte and all of the younger cells as non-filaments. Nonfilament counts rise with infection, whether the total count rises or falls. Filaments rise also, and the rise of both filament and nonfilament is a good prognostic sign, provided the nonfilaments do not outnumber the filaments. A rise of nonfilaments with a fall in the number of filaments is always a bad prognostic sign. The well-trained hematologist also recognizes changes in the staining character

of the nucleus and of the cytoplasm, which are of great value in determining the direction in which the infectious process is going. I do not mean this refers to body location, for obviously the blood picture hardly could indicate the site of infection, but whether the patient is reacting favorably to his infection, or unfavorably, is distinctly reflected in the blood picture. It is also important to remember that many infections are characterized by a rise in lymphocytes. Whooping cough is one of these. Some infections frequently show little change in the leucocyte count. It is also important to bear in mind that many noninfectious conditions, such as intraperitoneal hemorrhage, intracranial hemorrhage, coronary thrombosis, are also characterized by leucocytosis. The blood picture can reveal much of value in the diagnosis of disease and in the control of its treatment, but like many other valuable diagnostic aids, it frequently requires expert knowledge and experience for proper interpretation."

A vote of thanks was given to Mr. Herbert Addiscott, the superintendent of the hospital, for his gracious hospitality. The entire staff of the hospital was present, as well as many doctors from Atlantic City.

A delightful supper was served by Mr. Addiscott at 11:00 p. m., at the end of a very fine meeting.

The address by Dr. Konzelmann was very scientific and much advanced information was imparted by him. He was a former Professor at Jefferson Medical College and Temple University and is an eloquent, informative and delightful speaker.

CUMBERLAND COUNTY

Norman W. Henry, M.D., Reporter

The regular meeting of the *Cumberland County Medical Society* was held December 11, 1945, at 2:30 p. m. at the Cumberland Hotel, Bridgeton. Dr. G. N. Thomas presided. Twenty-two members were in attendance.

Dr. Muriel Ramsey, Secretary, reported the resignation of Dr. Edward Thalheimer as Chairman of the Insurance Committee. This work is to be turned over to the Secretary of the Society. She also advised all communications with reference to the Veterans Administration be forwarded to Committee Chairman Dr. Burton Walker, Dr. Albert Kump or Dr. Muriel Ramsey, who will represent this work in this county.

The November issue of the A. M. A. Journal in which appeared a picture of Dr. Barney Lihn of Vineland, has been added to the archives of our society. Dr. Barney Lihn was killed in military action in the European theater.

Dr. Joseph T. Kolbe of Milville was unanimously approved and passed by the society for membership. He recently transferred from the Westchester Medical Society of New York.

Dr. Frank Hughes, Obstetrician at the Cooper Hospital, Camden, related his experiences with regard to various obstetrical problems. His first subject was that of threatened abortion in which he felt that Progesterone and Stilbesterol constituted the medical treatment along with rest and sedation. In discussing the pre-natal care and its treatment, Dr. Hughes advocated a high protein, low fat and low carbohydrate diet. The administration of calcium capsules and wafers should not become a routine procedure as this organic substance can be obtained from milk. However, if there is a known deficiency of this factor, it is recommended that supplementary calcium be given. Vitamin therapy is fine for those individuals suffering a known deficiency but in general the American diet is adequate. He stresses the use of vitamin K in the last month of pregnancy. The total weight gain during pregnancy should be twenty pounds.

Pelvic examination includes the structure, size and shape of the cervix, keeping in mind the possibility of cervical dystocia, and pelvic measurements, especially the pelvic outlet.

With reference to pre-eclampsia and eclampsia these cases should be hospitalized, records kept for the blood pressure, total proteins of the blood, the NPN uric acid ratio in which 1:10 is normal. Intake and output records should be kept and eye grounds examined. In eclampsia, treatment consists of Morphine Sulfate, indwelling catheter, intravenous Magnesium Sulfate, Glucose and water. Sodium Phenobarbital as an anti-convulsive can be given frequently.

He concluded his discussion with a comparative value of the analgesics, i. e. Nembutal Scopolamine combination, Morphine Sulfate, Demerol alone and with Scopolamine, Caudal Analgesia, post partum care, anesthesia and the RH factor.

His talk was interesting, comprehensive and educational.

Dinner was served following adjournment.

ESSEX COUNTY

Anthony Ambrose, M.D., Reporter

The *Essex County Medical Society* Council met on Tuesday, October 23, 1945.

The Secretary read a letter from Dr. S. W. Johnsen, Chairman of the State Welfare Committee, regarding Medical Care of the Veteran, with enclosures describing the programs set up in Connecticut, Monmouth County, and the proposed program of The Medical Society of New Jersey. After much discussion, a motion was made, seconded and passed that the letter and enclosures be referred to the Economics Committee for prompt study and report.

The Secretary read a letter from W. G. Hazard of the Bureau of Industrial Health enclosing two copies of a report summarizing the findings of the physical examination demonstration conducted for members of Local 420 of the C. I. O. in Belleville in July, 1945. On motion made, seconded and passed, the report was referred to the Public Health Committee for report.

Dr. Crecca, President, informed the Council that Director Gray of the Freeholders is very much in favor of the proposed Blood Bank in Essex County.

Dr. Murray, Chairman Child Welfare Committee, distributed pictures for the inspection of the Council, taken of the exhibit held at Bamberger's during National Health Week. These pictures are to be sent to the four hospitals that donated material for the exhibit.

On motion made, seconded and passed, the Child Welfare Committee was given permission to send a

doctor to each hospital to address the Scientific Committee on the dangers of infectious diarrhea.

A folder from the National Physicians Committee, containing a speech by Samuel Gompers, written in 1916, was inspected by the Council. A motion was made, seconded and passed that a letter be written to Dr. Londrigan of the State Committee suggesting that the report by Gompers on Socialized Medicine be published in papers throughout the state, and that the money from the National Physicians Committee be used for this purpose.

On motions made, seconded and passed, it was decided that the County Society will give a dues credit or remission for members in the Armed Services, that the County Society will give a dues credit or remission to members serving with other war agencies, and that members of the County Society will be given a dues credit or remission for the first full year's dues after discharge from service.

Dr. K. E. Gardner again brought to the attention of the Council the matter of permitting competent chest physicians to treat private patients at the Essex Mountain Sanatorium. This question is still being studied by the Board of Freeholders and no final action has been taken by them as yet.

The Council met on Tuesday, November 27, 1945.

The Secretary read a letter from Lt. Col. William J. Carrington, M.C., stating that Samuel Gompers' address on Socialized Medicine has already appeared in the Saturday Evening Post. On motion, made, seconded and passed, it was moved that the letter be filed.

A letter was read from Mr. Speers of the Board of Freeholders in answer to our request for a resume of the Chronic Disease Hospital Program of their Committee. Mr. Speers stated that the Board of Freeholders did not clearly understand what we wanted, and that they will be very glad to furnish any information desired if they know exactly what we wish to know. Dr. Crecca stated that a meeting is to be held by the Chronic Disease Hospital Committee of the Board of Freeholders, Dr. H. N. Comando, Chairman of Chronic Disease Hospital Committee of the Essex County Medical Society, and himself, in the very near future, to discuss the matter. On motion made, seconded and passed, it was moved that this letter be filed.

Dr. Greifinger reported that the matter of liability protection for the Essex County Medical Society was taken up with Faulhaber & Heard, Inc., and that a policy was issued which covers the Society and its officers. It was moved that the full coverage be taken and that the policy be accepted.

A letter addressed to Mrs. F. A. Bien from Dr. Wells P. Eagleton in which Dr. Eagleton praised the wonderful service rendered by the late Dr. Frank Bien in medical legislation, was read. It was moved and passed that the letter be published in the Bulletin.

Dr. W. D. Crecca, President, reported that the Central Blood and Plasma Bank Committee will hold a meeting with the Board of Freeholders in the very near future to discuss the amount of money needed for the establishment of a Central Blood Bank. Dr. Crecca stated that the Committee was assured of the Freeholders' full coöperation in this matter.

Dr. Greifinger, Chairman of the Medical-Legal Testimony Committee, reported that the Committee has invited all the Judges of the various courts in Essex County to an informal dinner to be held on December 4, 1945, for the purpose of discussing the objectives in elevating the type of Medical-Legal testimony given in the various courts.

The Chairman, Dr. J. W. Hurff, brought up the matter of the Veterans Administration Liaison Committee Report which was sent to all members of the Council for study and approval. Dr. Schaaf reported that the Board of Trustees of the State Society endorsed the principles of our report and also the Monmouth County report and they are going to formulate a plan for state-wide adoption. After much discussion, motion was made that the Special Veterans Administration Meeting be postponed for the time being, and that the Veterans Administration Liaison Committee Report be accepted, subject to amendment by the State Society. This motion was seconded and passed.

The appointment of a Medical Director of the State Department of Labor, which includes the Workmen's Compensation Bureau, was again discussed. On motion made, seconded and passed, it was decided that a postcard be sent to all members of the Essex County Medical Society informing them of this opportunity and asking them to inform us if they are interested.

HUDSON COUNTY

Harry J. Perlberg, M.D., Reporter

A regular meeting of the *Hudson County Medical Society* was held on December 4, 1945, at the Masonic Club in Jersey City.

The following were elected to membership: DR. EDITH MANGONA, DR. MATTHEW L. SCHIMENTI, DR. JOHN E. ANNITTO, of Jersey City; DR. MILTON E. SILON of Hoboken; and DR. NORMAN KORNFIELD of Kearny.

DR. PAUL J. MIRANTI of Weehawken was passed by the Board of Censors for reinstatement.

DR. ANTON CZIRAKY, Union City, was transferred from Wyandotte County Medical Society, Kansas City, Kansas.

The following program, of exceptional interest and merit, was presented by the Medical Staff of Christ Hospital, Jersey City, of which Dr. Lawrence V. Lindroth is president:

1. The Surgical Treatment of Esophageal Diverticulae, DR. FRANK BORTONE.
2. Some Sequelae of Urethral Manipulation, DR. IRWIN MARKOWITZ.
3. Hypertrophic Sigmoid Diverticulitis, DR. LOUIS LANGE.
4. X-ray Demonstration of Diverticulosis of the Digestive Tube, DR. WILLIAM WALLACE MAYER.
5. Fresh Pathology in Kodachromes, DR. A. J. GITLITZ.

The meeting adjourned at 11:55 p. m.

WOMAN'S AUXILIARY

PRESIDENT'S MESSAGE

MRS. WILLIAM E. DODD

Again we stand at the beginning of a new year—a year which no doubt will determine many things relating to the interest of the Woman's Auxiliary. In retrospect, we might enumerate our accomplishments, but it is pertinent that we "Look Ahead" and prepare ourselves for a greater service.

At the recent meeting in Chicago, the House of Delegates to the American Medical Association adopted the following resolution:

Whereas, The object of the Woman's Auxiliary is to aid the American Medical Association in every way requested; and

Whereas, The most urgent need at the present time is for widespread dissemnaiton of knowledge concerning the hazards of current medical legislation; therefore, be it

Resolved, That the House of Delegates of the American Medical Association requests the Woman's Auxiliary to use every avenue possible to bring such information to its members and through them to the public.

With this direct appeal we can not stroll casually down the crossroads of medicine. With the publicity spotlight being turned on full glare on the new Bill, S. 1606, formerly the Wagner-Murray-Dingell Bill, it is our duty as Auxiliary members to become fully acquainted with the bill and be able to point out the deliberate attempt to confuse the public by omitting all mention of cost or taxation necessary for its functioning.

Dr. W. W. Bauer, Director of the Bureau of Health Education of the American Medical Association, pointed out that it would mean a 15 to 17 per cent taxation to meet the cost, and even then it is doubted the amount would be sufficient.

Educate yourself, your busy husband and another doctor's wife. Together we can clarify the bill and inform the public that only the American Medical Association can offer the proper solution for medical care.

KNOW YOUR COUNTY AUXILIARY PRESIDENTS

Gloucester County

MRS. FRED J. FAUX



Mrs. Fred J. Faux of 32 North Columbia Street, Woodbury, our President for this year, has been a member of the Auxiliary for four years. Last year she served as Vice-President and Bulletin Chairman.

Mrs. Faux is the mother of a three-year old son, Bobby, and recently her husband has been made Lieutenant Commander in the U. S. N. R. Dr. Faux has served in the Navy the last three and one-half years and is hoping to return to civilian practice by January, 1946.

Dr. and Mrs. Faux are both natives of South Jersey.

Hudson County

MRS. EDWARD A. MURPHY



Mrs. Edward A. Murphy of 45 Highland Avenue, Jersey City, was installed as President of the Woman's Auxiliary to the Hudson County Medical Society on April 2, 1945. She has been an active member for many years, serving as Corresponding Secretary and Chairman of Hostesses.

Mrs. Murphy was born in New York City, the daughter of the late Mr. and Mrs. Theodore Smith, Sr. Her father, a well-known industrialist, was the founder and president of the Theodore Smith & Son's Company Shipyards and Iron Works, and was the inventor of the Orange Peel Bucket dirigible.

Mrs. Murphy is an alumna of St. Aloysius Academy, a member of The à Kempis, The Children of

Mary of St. Teresa, and served on the Philharmonic Guild.

She is the mother of two children, Edward II and Jean Marie. Edward, a graduate of Lincoln High School, has served in the United States Coast Guard for three years. Jean Marie, a graduate of St. Dominic Academy, is a student in the sophomore class at Manhattanville College of The Madames of The Sacred Heart, New York.

FUTURE EVENTS

ESSEX—The regular meeting of the Woman's Auxiliary to the Essex County Medical Society will be a luncheon meeting at 12 o'clock noon, Monday, January 28, 1946, at the Academy of Medicine. This will be followed at 2:00 p. m. by a symposium on Rehabilitation of the Returning Veteran presented in three phases: the orthopedic, plastic restorations, and the neurological and psychiatric aspects.

GLOUCESTER — The January meeting of the Gloucester Auxiliary will be held on Thursday, the 24th, at 1:00 p. m. at the home of Mrs. William Pedrick, Glassboro. It will be a business meeting and luncheon.

MIDDLESEX—The next meeting will be held on Wednesday, February 20, at 8:30 p. m. This session will be devoted to the making of cancer bandages as the group hopes to fill a definite quota. A social meeting and card party will be held March 13 at 8:30 p. m.

AUXILIARY REPORTS

Atlantic County

Mrs. Samuel Salasin, Chairman of Publicity

One of the gayest of Atlantic City's holiday celebrations was that held Friday evening, December 14, 1945, by the *Woman's Auxiliary to the Atlantic County Medical Society* at the home of Mrs. James H. Mason, III.

Decorations were very elaborate and novel. Guests arriving passed a large poster of Santa Claus, before being welcomed at the door by Mrs. Robert Bradley, President of the Auxiliary. The table was very striking with pine boughs and cones, large red and white candles and a number of old-fashioned red and green Christmas balls. Outstanding features of the evening included group singing of Christmas carols, a series of progressive games, and solos by Dr. Robert Bradley, tenor, accompanied by Miss Irene Buzone.

Mrs. Anthony Merendino and Mrs. Max Gross headed the committee on arrangements for the party, assisted by Mrs. James Mason, III, Mrs. Robert Bradley, Mrs. Samuel Goldstein, Mrs. David B. Allman, Mrs. G. Ruffin Stamps, Mrs. V. Earl Johnson and Mrs. Samuel L. Salasin.

During the evening it was announced that the Auxiliary is donating $50 to the Camp and Hospital Committee for the Double Amputee Club of the Thomas M. England Hospital.

Essex County

The *Woman's Auxiliary to the Essex County Medical Society* held its regular meeting at the Academy of Medicine on November 26, 1945. Luncheon was served at noon by Mrs. David A. Stern and Mrs. John R. O'Sullivan, members of the Hospitality and Hostess Committee, followed by the meeting at 1:00 p. m.

Following the meeting a debate on the Wagner-Murray-Dingell Bill, one of a series of open meetings for health discussion to be sponsored by the Auxiliary, took place. Seven hundred and fifty invitations were sent to all civic, welfare, religious and social groups of the community. The President, Mrs. S. Bernard Kaplan, opened the session and turned it over to Mrs. Lodovico Mancusi-Ungaro, Co-chairman, with Mrs. Asher Yaguda, of Public Relations.

Lewis Hermann, editor of The New Jersey Labor Herald, and Dr. Frederic J. Quigley, Executive Secretary of the Legislative Committee of The Medical Society of New Jersey, took opposing sides. Mr. Hermann, who took the affirmative, described health insurance as an important step in the right direction. He pointed out the bill is not socialized medicine. Dr. Quigley argued that plans similar to that recommended by President Truman and embodied in the bill have been unsuccessful in other countries. The proposed plan provides for prepayment of the cost of illnesses and the intention is to reach the total population. Mr. Hermann declared, "It is not socialized medicine. Socialized medicine would make all physicians government employees." As proof of the need of such a plan of health insurance, Mr. Hermann pointed to records of rejections because of physical disabilities of men in the draft. Declaring that labor is for the bill and for President Truman's proposals, he said, "We fear unless we have this, the crackpots in Washington will give us what we do not want."

The history of similar legislation in other countries was outlined by Dr. Quigley, beginning with Germany. He said it has not been successful in any, including England, if measured by resulting health conditions. "We have become the wealthiest nation and the highest in health standards under free enterprise," he added. "One of the matters taken up in the bill," Dr. Quigley pointed out, "is extension of maternity and child health care. We need it in this state as much as a dog needs two tails. The good maternity conditions in this state are due entirely to organized medicine. The work

here has not been accomplished through federal aid but by coöperation of the medical profession and the state."

Dr. J. Wallace Hurff of Newark, a former President of the County Medical Society, spoke on an alternative plan, as proposed by The Medical Society of New Jersey, citing the Medical-Surgical Plan as carried out in the state and in Newark. Dr. Hurff pointed out that these plans had started to develop in 1938 and that legislation was offered the following year approving the plan. Newark's plan, he said, assures the patient of the right to make his choice of a physician and has reduced the cost to the city of the care of the indigent sick. "We know that government controlled medicine has failed wherever tried. Compulsory insurance is unnecessary," Dr. Hurff declared.

Hudson County

Mrs. Sidney Chayes, Chairman of Publicity

The *Woman's Auxiliary to the Hudson County Medical Society* met Monday afternoon, December 3, 1945, at the Young Women's Christian Association in Jersey City.

Mrs. Edward Murphy, President, presided at the short business meeting.

The Auxiliary is going to promote a Cancer Educational Program. Mrs. Samuel Scott and Mrs. Samuel Barishaw are Co-chairmen of the committee.

Mrs. A. C. Ruoff, Chairman of the Reciprocity Day, announced that the speaker will be Dr. Phillip Levine of the Ortho Research Foundation.

A Christmas party followed the regular meeting. Mrs. Murphy welcomed the members and their guests with a happy Christmas message of peace and understanding. Christmas carols were sung, with Mrs. Harry Perlberg at the piano.

Mrs. William Gleason, Chairman of Program, introduced Miss Rose Tardy and Miss Beatrice De Marco of Jersey City, John McKenna and Patricia Jennings of Bayonne. These talented young people entertained with vocal selections. "A Prayer of Peace" by Norman Corwin was read by Mrs. Ben Markowitz and entertaining monologues were given by Miss Mary Higgins.

Tea was served, with Mrs. Abraham Jaffin pouring.

Middlesex County

Mrs. Norman Rosenberg, Chairman of Publicity

The *Woman's Auxiliary to the Middlesex County Medical Society* held a Christmas party Wednesday, December 19, 1945, at the home of Mrs. Robert J. Walker, Highland Park. Games were played and gifts were exchanged.

At the conclusion of the meeting the hostess explained the various health programs which New Jersey offers for the better distribution of medical care.

BOOK REVIEWS

Pictorial Handbook of Fracture Treatment. By Edward L. Compere, M.D., F.A.C.S., and Sam W. Banks, M.D. Pp. 351, illustrated. Chicago, Year Book Publishers, Inc. 1943.

Dr. Compere serves the needs of the medical student, general practitioner, the industrial surgeon and the army medical officer with this quick reference book of fractures and modern methods of treatment. Illustrations are vivid, numerous and excellent. Symptoms, diagnosis and treatment, anesthesia, splinting and after-care are included. The author's approach is new and different and should meet the approval of all who want the latest in fracture work. This pictorial handbook merits an important place in the practitioner's library.

Louis Simonson, M.D.

Preventive Medicine. By Mark F. Boyd, M.D., M.S., C.P.H. 7th ed. Pp. 591, illustrated. Philadelphia & London, W. B. Saunders Company. 1945. $5.50.

In his foreword Dr. Boyd states that this volume was written particularly for physicians and that "the medical profession can and must play an important rôle in the field of preventive medicine and public health. At present physicians are neglecting their opportunities. If this neglect continues, opportunities will lessen and the field will be taken away from physicians by a changing public sentiment."

The relationship of water to health and disease is excellently covered, including a full description of the sanitary measures needed to control epidemic diseases. The public today is hungry for knowledge of what should be done to maintain health and efficiency in the family circle, and the practitioner will find it in this book.

Normal food requirements are described in easily understood language with an excellent description of disease due to dietary deficiencies. The chapters on industrial hygiene are finely illustrated and the subject is presented in the modern manner, including sections on the control of industrial disease.

Dr. Boyd's book has filled a long felt want in presenting preventive medicine in a volume that is not too cumbersome but which adequately covers a subject which the physician more and more will be called upon to expound in the routine of his practice.

Charles V. Craster, M.D.

Tuberculosis Abstracts

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XIX **January, 1946** **No. 1**

FOR tuberculous meningitis there is still no adequate therapy. Therefore, before such a diagnosis is made, one must be sure to rule out all diseases for which medical or surgical treatment might be beneficial and in which the prognosis might be favorable.

TUBERCULOUS MENINGITIS — A CASE REPORT

Presentation

A five-year-old boy was admitted to the hospital with headache, listlessness and fever. Three weeks before admission the patient became listless and ten days later developed a fever of 102° F., with nausea followed by frontal headache and persistent vomiting. There were no chills, convulsions or paralysis.

Physical examination upon admission revealed a thin, poorly developed child responding clearly to questions but lapsing into drowsy stupor when undisturbed. The skin was clear and of good color. The ears, throat and fundi were normal. Small cervical lymph nodes were palpable bilaterally. The neck was stiff and painful on flexion. The heart, lungs and abdomen were negative. The Kernig sign was doubtful. The deep tendon reflexes were active and equal. The temperature was 99.4° F., the pulse 100, and the respirations 24. The blood pressure was 100 systolic, 75 diastolic. Blood examination revealed a red-cell count of 5,220,000 with 108 per cent hemoglobin. The white-cell count ranged from 10,200 to 20,650 with 74 per cent neutrophils. The urine was essentially negative. A tuberculin test was negative in a dilution of 1:1000, but positive at 1:100. Blood cultures were negative.

A roentgenogram of the chest revealed a slightly hazy left lung field but no areas of consolidation. There was no enlargement of the hilar nodes.

A lumbar puncture revealed clear colorless fluid under a pressure equivalent to 250 mm. of water. The total white-cell count was 95, with 70 per cent polymorphonuclears. The total protein was 105 mg. per 100 cc., the gold-sol curve 0012333100, and the Wassermann test negative.

The temperature ranged between 100° and 102° F. Repeated lumbar punctures revealed pressures up to 550 mm., the fluid becoming opalescent and a cell count rising to 350. A sugar determination was 39 mg., and the chloride 567 mg. per 100 cc. Spinal-fluid cultures were negative, as were smears for acid-fast bacilli. A throat culture revealed a Type 22 pneumococcus.

Sulfathiazole therapy was begun on the sixth hospital day. Two days later a neurologic examination revealed a patient difficult to arouse and with dilated pupils, fixed to light. There was no papilledema. The gaze wandered but tended to be directed toward the right. There was a left hemiparesis, with increased tendon reflexes and an extensor plantar response on the paretic side. There was a positive Kernig sign. Death occurred on the tenth hospital day.

Differential Diagnosis

Dr. Allan M. Butler: From the information, no definite diagnosis can be made. The sequence of respiratory infection, fatigue, listlessness, moderate fever, nausea, headache and persistent vomiting is consistent with the dissemination of a primary tuberculous focus and the development of tuberculous meningitis, but does not exclude influenzal meningitis, brain abscess or encephalitis.

The mental state of the child and the stiff neck are consistent with tuberculous meningitis. A positive tuberculin test in a child of five suggests continued exposure at home or the ingestion of unpasteurized milk. Resistance to tuberculosis is relatively good at five years of age and the incidence of tuberculous meningitis is markedly less at this age than at one, two or three years. Unfortunately, no information is given concerning the presence or absence of continued exposure.

The description of the roentgenogram of the chest is noncommittal. The films are not available for re-examination, but they were interpreted as essentially negative.

The spinal-fluid sugar of 39 mg. per 100 cc. and the other relatively normal spinal-fluid sugar levels do not rule out tuberculous or other bacterial infection. Without the hyperglycemia incident to the parenteral glucose they might have been markedly diminished. Lack of information about the serum chloride concentration deprives the low spinal-fluid chloride of diagnostic significance. The occurrence of 70 per cent polymorphonuclear cells is rare in tuberculous meningitis but not impossible.

The failure to identify organisms on smear is consistent with encephalitis, brain abscess or tuberculous meningitis. The influenza bacillus may also be missed. The failure to culture organisms is also nonspecific. If the meningitis were due to a Type 22 pneumococcus, the spinal fluid would have been purulent and the organisms seen or recovered on culture.

Sulfathiazole was not administered until the sixth hospital day. Such therapy did not interfere with culture of the spinal fluid. It indicates the diagnosis of tuberculous meningitis was not clearly established. The progress of symptoms is not diagnostic. The repeated lumbar punctures may well explain the absence of papilledema. The possible diagnoses appear to be tuberculous meningitis, with or without miliary tuberculosis, influenzal meningitis, encephalitis and, finally, brain abscess.

I shall hazard the diagnosis of tuberculous meningitis, with or without miliary tuberculosis.

Clinical Diagnosis: Meningitis (? tuberculous).

Dr. Butler's Diagnosis: Tubercular meningitis. Miliary tuberculosis?

Anotomical Diagnoses: Tuberculous meningitis. Miliary tuberculosis of lung, liver, spleen, kidneys and bone marrow.

Pathological Discussion

Dr. Charles S. Kubik: Autopsy revealed tuberculous meningitis and miliary tuberculosis of the lungs, liver, spleen, kidneys and bone marrow. I should suppose that the listlessness and loss of appetite noted before entry were the symptoms of generalized miliary tuberculosis and that the onset of meningitis coincided with the headache and vomiting.

On examination of the brain a subarachnoid exudate was observed, more pronounced over the base of the brain and the brain stem than elsewhere. Numerous tubercles of the arachnoid and pia could be seen and were later confirmed by microscopic examination. The lateral and third ventricles were enlarged to about four times normal size. The ependyma was studded with tiny, barely visible tubercles that gave the ependymal surfaces a roughened appearance.

There was also a tubercle, 2 mm. in diameter, of the right cerebral peduncle, which may have accounted for the left hemiparesis. No other tubercles within the substance of the brain were found.

Case Records of the Massachusetts General Hospital, The New England Journal of Medicine, January 25, 1945.

SUPPLIED BY

New Jersey Tuberculosis League

15 East Kinney Street, Newark 2, New Jersey

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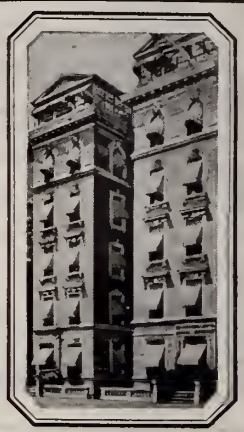
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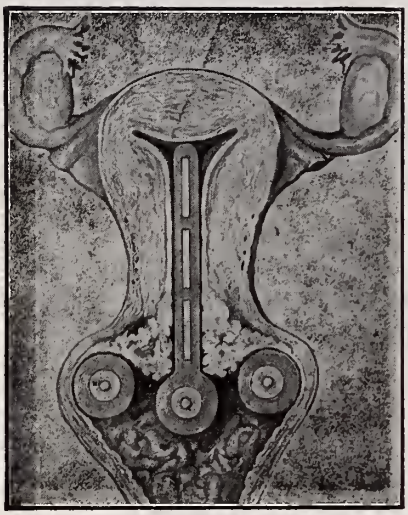
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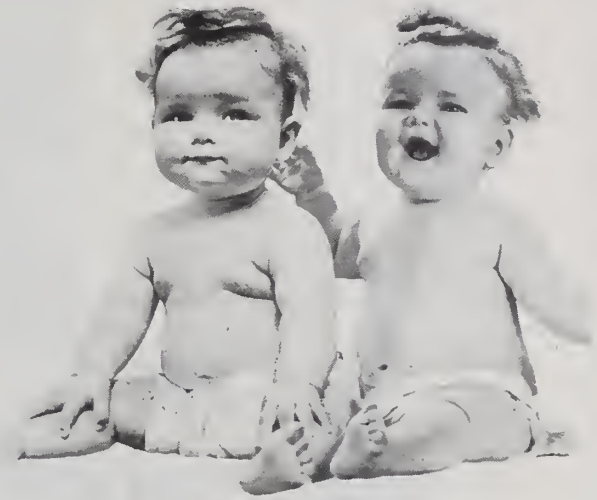
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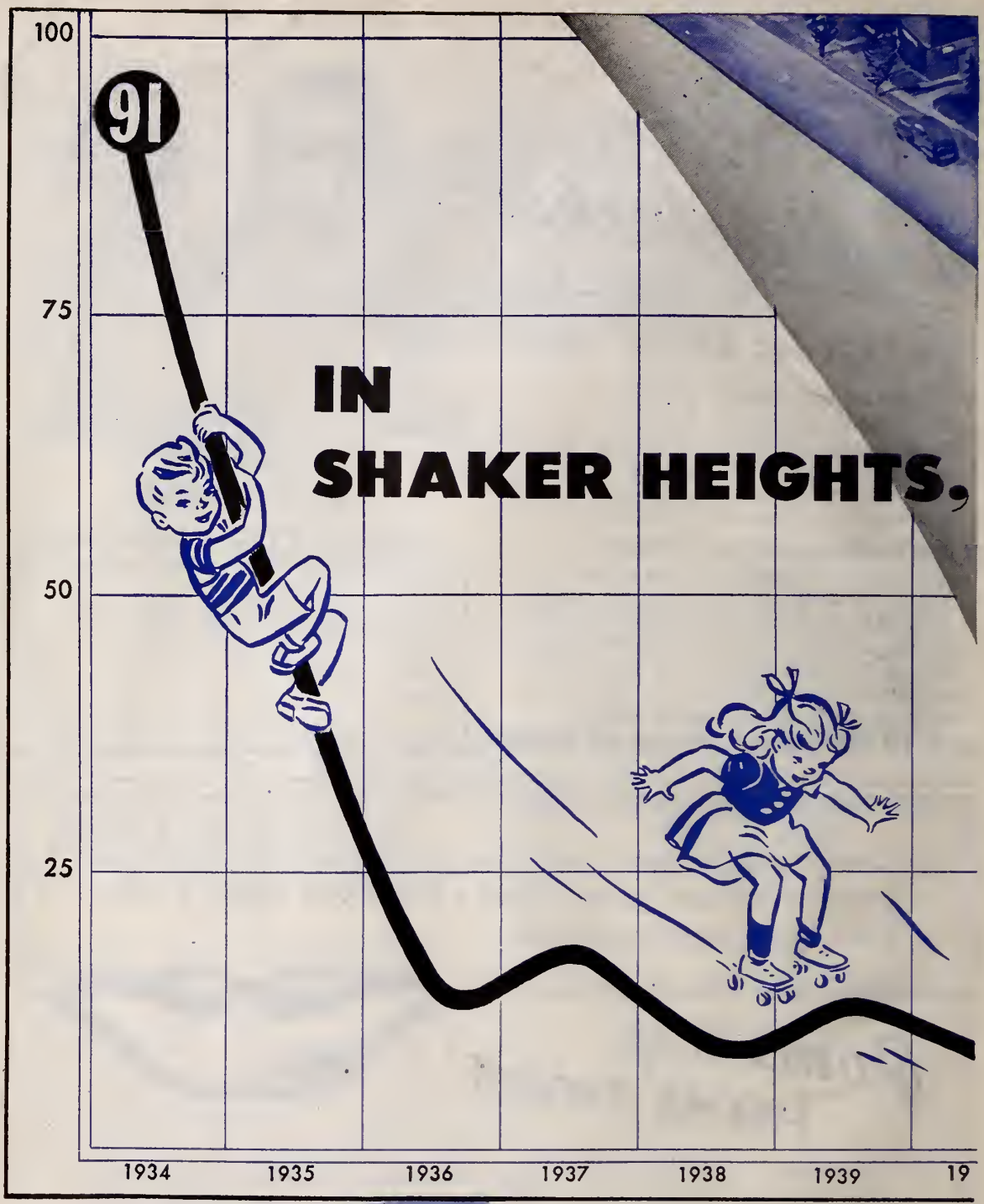
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Place of Publication, Printing and Mailing:
12 SOUTH DAY STREET, ORANGE, NEW JERSEY

Entered as second-class matter, September 5, 1906, at the post office at Orange, New Jersey, under Act of March 3, 1879.

VOL. 43, No. 2 — FEBRUARY, 1946 — Subscriptions, $3.00 per Year; Single Copies, 30 Cents

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PLACE OF PUBLICATION, PRINTING AND MAILING, 12 SO. DAY ST., ORANGE, N. J.
EXECUTIVE AND EDITORIAL OFFICES, 315 WEST STATE ST., TRENTON 8, N. J. TEL. 5776

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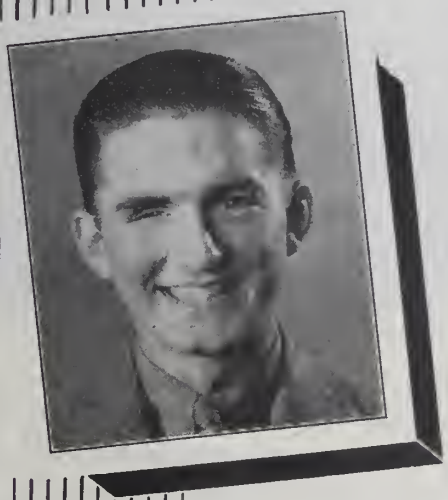
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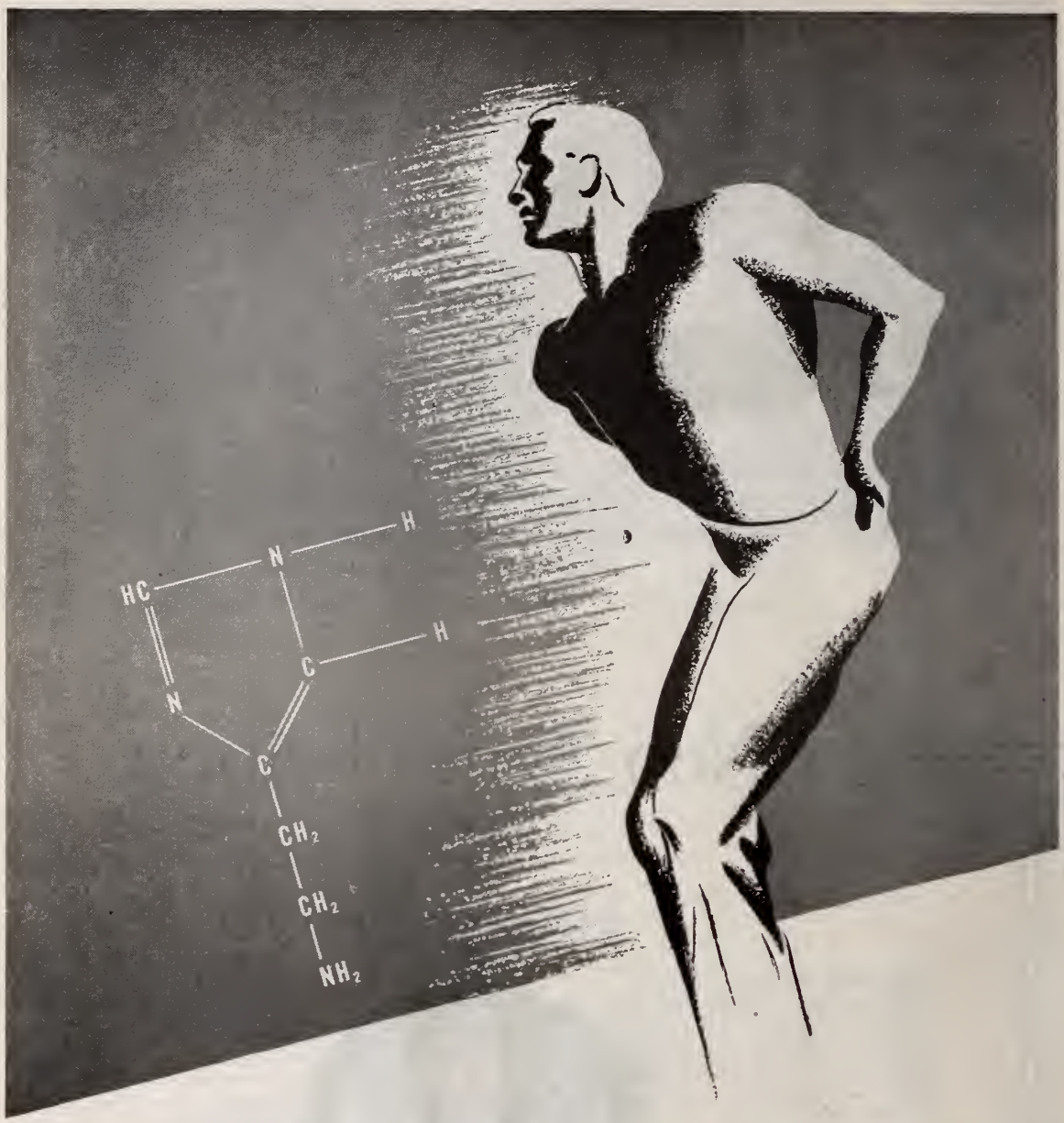
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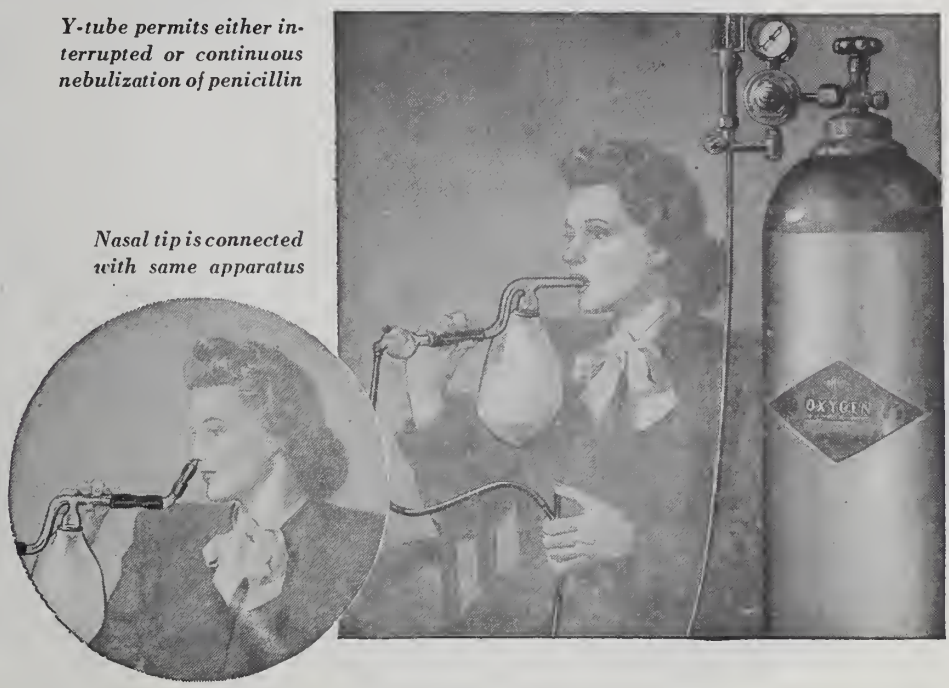
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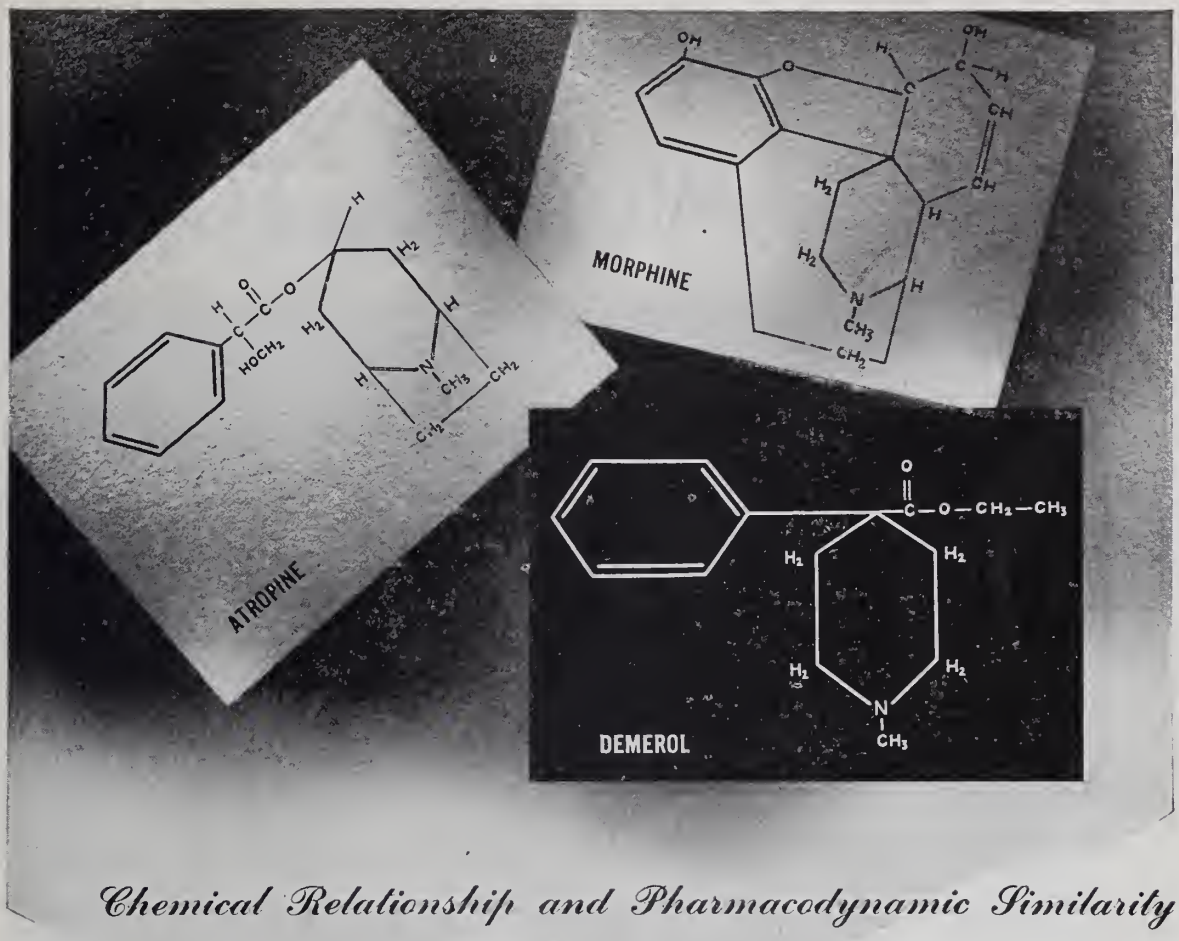
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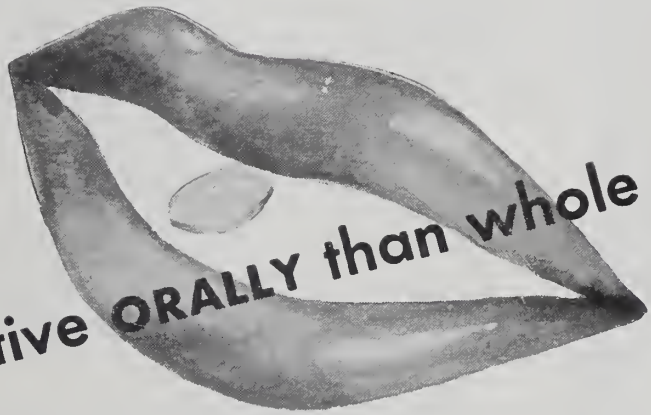
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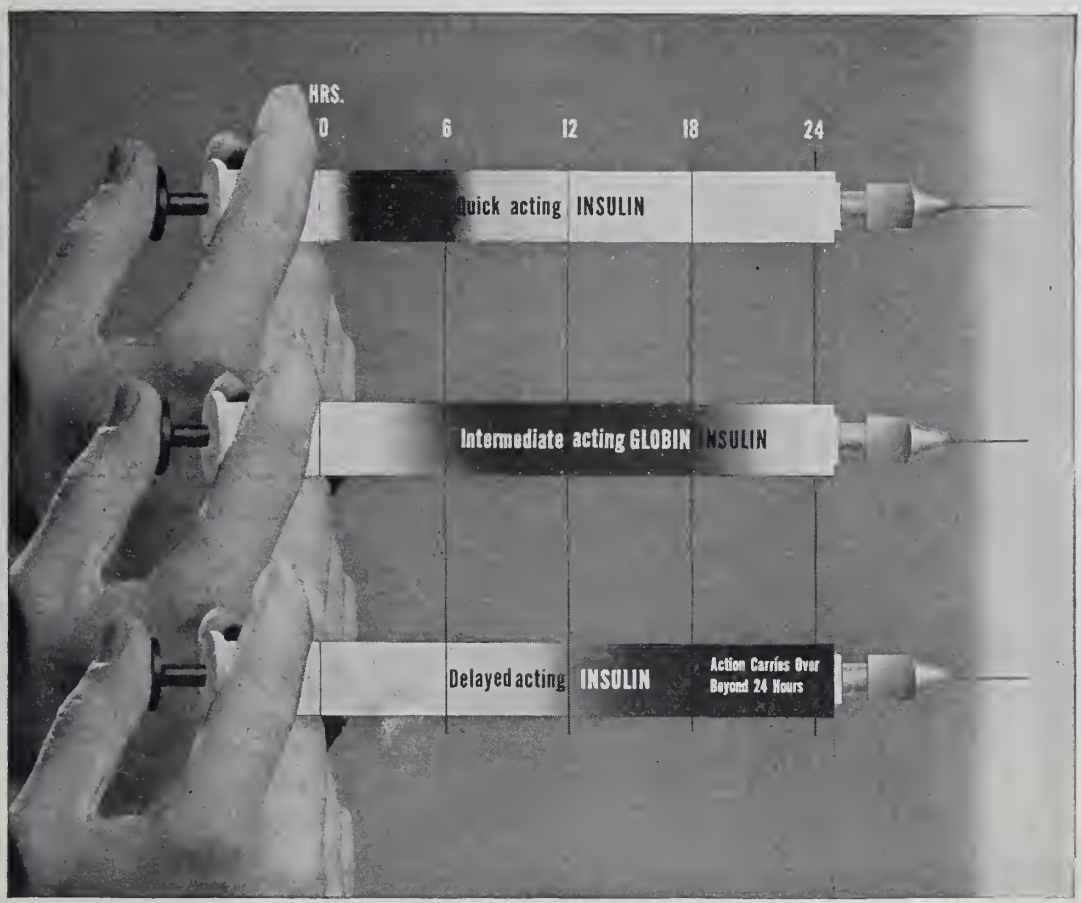
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Effective Salicylate Therapy Without Sodium Bicarbonate
1.—Smull, K., Wégria, R., and Leland, J., J.A.M.A. 125:1173 (Aug. 26) 1944.
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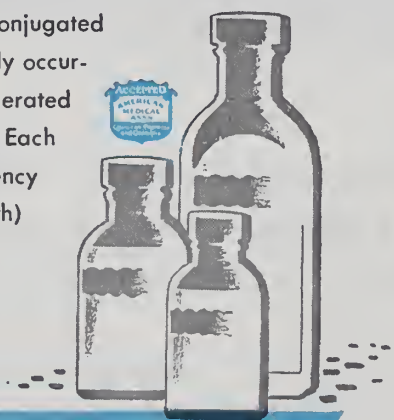
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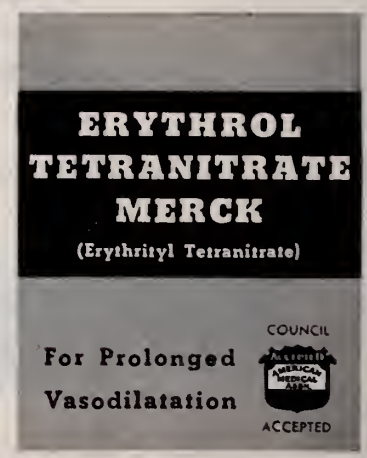
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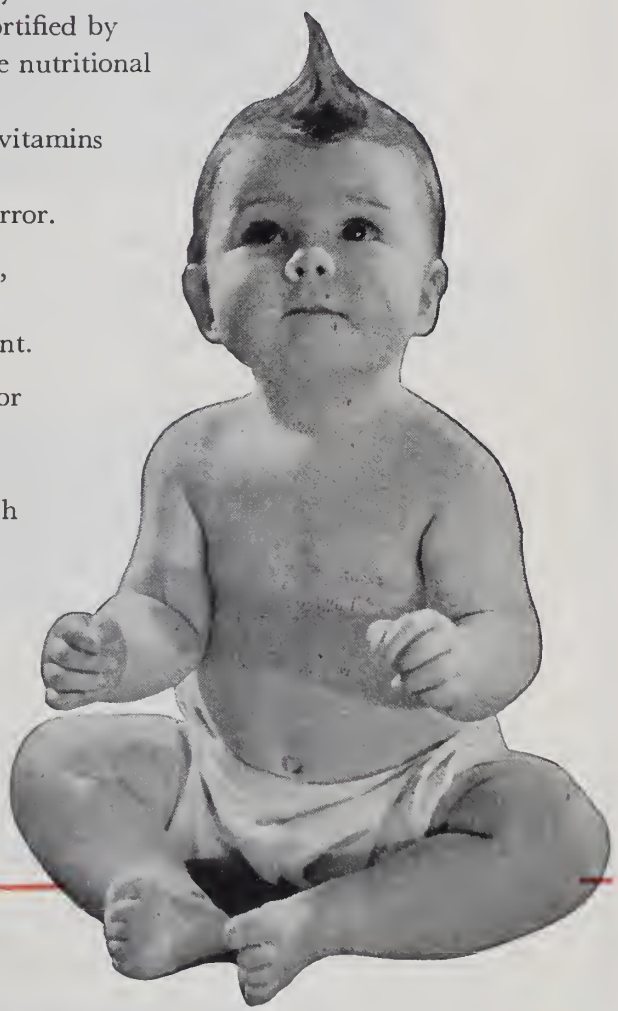
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. . . a Captain in the Fighting French
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THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Published Monthly Since September, 1904
Whole Number of Issues, 498

Under the
Direction of the
Committee on Publication

Henry C. Barkhorn, M.D., Chairman

Henry A. Davidson, M.D., Editor

Place of Publication, Printing and Mailing—12 South Day Street, Orange. N. J.
Editorial and Executive Offices of the Society—315 West State Street, Trenton 8, N. J.; Tel. 5776
Each member of the State Society is entitled to receive a copy of The Journal every month.

Vol. 43, No. 2 February, 1946 Subscriptions, $3.00 per Year
Single Copies, 30 Cents

EDITORIALS

ANDREW FRANCIS McBRIDE, M.D., K.S.G.

For two weeks, flags on all city buildings in Paterson have flown at half-mast. This was the city's tribute to the passing of a man who had been cited in 1931 as "Paterson's Outstanding Citizen." But his city is only one of the many institutions which clamored to honor Dr. Andrew Francis McBride during his long and useful life-time. He had been honored by his state, by his Church, and by his profession.

Dr. McBride is gone. He died on the eve of his 77th birthday, bringing to a close a career which touched every aspect of the community's life. For 15 years he served the local Board of Health, half that time as its President. He was Passaic County Physician for more than a decade. And for six eventful years he was the mayor of Paterson. During his term of office he manifested an interest in the city's schools, playgrounds, markets and parks, that was not only warm and human—but that was extraordinarily effective. They still tell of how many schools he caused to be built, how many playgrounds he opened, how many parks he set up as breathing spaces in his highly industrialized community. It was a measure of his extraordinary range of interest that he organized for Paterson both a Chamber of Commerce and a Shade Tree Commission. He set up a Tuberculosis Hospital and a training school for firemen. And during the period of ceaseless municipal improvement, the city tax rate steadily fell. Here was a doctor who could not be classed as an impractical visionary!

At the start of the first World War he abandoned a lucrative practice and a position of considerable civic prominence to accept a captain's commission in the Army. And during that brief war, he rose rapidly from captain to lieutenant-colonel.

He served the State as well as the city. From 1923 to 1928 he was New Jersey's

Commissioner of Labor, the first physician to fill that important post. At the close of his career in that department, he was made president of the International Association of Industrial Accident Boards.

Dr. McBride served his fellow-man without stint. And he was a devoted and zealous servant of God. Long recognized as one of the distinguished laymen of his Church, he was honored in 1939 by designation as a Knight of St. Gregory. Bishop McLaughlin, speaking of his tireless work in the cause of the Church, once said: "Dr. McBride is known to all in Paterson with whose joys and sorrows his entire life has been associated."

The medical profession of this state has given to Dr. McBride every honor at its disposal. He was one of the few men in the country to achieve honorary membership in The Medical Society of New Jersey. President of the County Society, Chairman of the State Welfare Committee, Trustee, A. M. A. Delegate, Chairman of the Board of Trustees and, in 1928, President of The Medical Society of New Jersey—these are only a few of the many posts in which he labored on behalf of his fellow-practitioners. He worked indefatigably, persistently—and effectively—for the establishment of the Society's own Home building in Trenton. A complete list of the honors that the Society bestowed on him would still fall short of measuring the loss we have sustained. Beyond the inestimable services which he concretely rendered to Organized Medicine, stands Dr. McBride as a symbol. A symbol of his conviction that a good doctor must also be a good citizen, that no physician is too busy to render important communal service, that active participation in civic affairs adds to the stature of the professional man. Certainly he gave us all an impressive demonstration of the fact that happiness is achieved through many-sided service.

We say farewell to a good doctor, a valiant worker for his God, his community and his fellow-man.

SCAPEGOAT FOR MEDICAL VETERANS

Troubled with grievances, the medical veteran looks for some agency to blame, and too often thinks he has found it in Organized Medicine. His thesis runs something like this: when it came to getting us *into* the Army or Navy, the medical societies did an efficient, fast-paced job. When it came to getting us *out of* the service, they pleaded impotence. Well, we are back in civilian life, but we can't find office space or living accommodations; our patients have new doctors. Those of us who entered the forces direct from internship or residency, find now that most hospitals have closed their doors to us, since they are already overcrowded and overstaffed. We need help. The medical societies have adopted resolutions of praise and sympathy. But we are still without offices, practices, hospital connections or homes. Organized Medicine has disappointed us.

Let it be said at once that these grievances, as such, do have substance. In blaming the societies, however, the physician-veteran is missing the mark. Consider first, the retort that the A. M. A. could have facilitated the demobilization of doctors if it had wanted to. Of course it wanted to. Every organization wants to increase its active membership rolls, and thus medical societies would have had every reason (even from a purely selfish viewpoint) for hastening demobilization.

Before he donned uniform, the doctor was a civilian, and as such beyond the authorty of the War or Navy Departments, but responsive to the pressure of his colleagues. Once commissioned, he was entirely under the jurisdiction of the Army or Navy. It has been said that the A. M. A. might have exercised political pressure to effect speedier demobilization. The wisdom as well as the effectiveness of such a course is open to serious question. When ex-policemen could not be released to furnish much needed service in many cities, when technical experts of all sorts had to be retained in the forces, how could the doctors have demanded preferential treatment? The situation is *not* parallel to the problem of procurement at the beginning of the war. Then it was a matter of the Army or Navy exercising pressure on the medical societies. Now the cry is for Organized Medicine to exercise pressure on government departments: quite a different problem.

The physician-veteran's other grievances must be solved at the community level rather than at the national level. Problems of hospital connections, office-space, and recapturing of practice, are obviously too localized to respond to any single nationwide answer. The shortage of living quarters is not peculiar to doctors, and other agencies can meet this difficulty far better than professional societies. How about the other three grievances: office-space, reestablishment of practice and hospital connections? Here the local medical society does have a legitimate interest and a genuine duty. As to office-space, what can we ask a county medical society to do? To erect a new building to accommodate the needed offices? Hardly. To urge practitioners to share their space, to maintain a central registry where rental information is available and to facilitate the sending out of announcements. That is all we can expect. And most county societies in New Jersey are doing just that. The hospital connection problem offers more scope for constructive action by the society. Practitioners who were established before the war find no difficulty in resuming their hospital assignments. The nub of the problem is the group of young men who had entered the Army or Navy before they had entered private practice. Here county societies can and should persuade hospital staffs to open their doors to these new doctors. Perhaps local policies make it impractical to admit many newcomers to the active staff. But certainly these veterans should be permitted to bring in private patients, under suitable supervision and to the extent that space permits. An attitude of utter exclusion will mean that the young doctor will have to turn over his patient to a staff-member or that he will be encouraged to treat at home patients who should be hospitalized. Worse than that, it will leave in the community an unassimilable mass of embittered young physicians whose existence will impair the unity of the profession. How about the recapture of lost practices? This is ultimately a matter of individual conscience. It is not the American way to compel a patient to go to a certain doctor, nor to compel a doctor to abandon a certain patient. The returning physician's best approach here is through further identification with his medical society, not through aloofness from it. The more he is accepted as a full-fledged member of his medical community, the more legitimate and effective will his claim seem.

The returning medical officer does have something to shoot at. But to aim at his own organization is to miss the target.

VETERANS' CARE CONTRACT SIGNED

Plan goes in operation March first

On January 29, 1946, Medical Service Administration, acting for The Medical Society of New Jersey, signed a contract with the Veterans Administration under which medical care of service-connected disabilities among veterans will be available by *private physicians chosen by the veteran.*

Included in the eligible services is the physical examination of the veteran applying for a pension. This constitutes the most important immediate part of the program. It is estimated that 142,000 New Jersey veterans are now awaiting such examinations.

If you have not submitted your name through your County Society as willing to participate in this work, will you please send your name directly to Medical Service Administration, 31 Clinton Street, Newark 2, New Jersey, stating your specialty or the fact that you are a general practitioner? We would also appreciate a statement as to the number of physical examinations you would like to have referred to you each month. We expect to have the Plan in operation March 1st.

Below is a copy of our contract and fee schedule. The fees as stated include 8 per cent as the administrative cost of the Plan which will be deducted from the fees when paid to physicians. Thus a listed fee of $5.40 for a hospital visit includes 40 cents for administration so that the physician actually receives an even five dollars. This accounts for the odd numbers in which the fees are expressed. Attention is directed especially to the fees for examinations (Section VI) which are listed beginning on page 40.

CONTRACT

Medical Service Administration of New Jersey agrees to make available during the fiscal year ending June 30, 1946, all services outlined below in accordance with the terms and conditions hereinafter prescribed:

(1) Medical Service Administration will arrange, through physicians registered with it for the rendition of the medical services covered by this agreement, for examinations, treatments and counsel in such cases as may be authorized by the Veterans Administration, Medical Service Administration reserving the right, however, to decline any particular case.

(2) The Veterans Administration will authorize examinations, treatments and counsel. All authorizations for such services to be rendered New Jersey veterans, except laboratory, x-ray and physical therapy services to be rendered veterans while bed patients in hospitals as a hospital service will be issued to the Medical Service Administration; Medical Service Administration will advise the veteran to report to a physician of the veteran's selection in his community, such *selection to be limited to those physicians registered with the Medical Service Administration* for the rendition of services under this agreement.

(3) Medical Service Administration will be responsible to see that reports required by the Veterans Administration are in proper form and that proper records are maintained which will be available for review by the Veterans Administration at any time. The Veterans Administration will review reports of services and will return to Medical Service Administration for further action, without additional cost to the Veterans Administration, those which do not meet the requirements of the Veterans Administration.

(4) *Fees for medical services will be in accordance with the fee schedule, which is attached hereto and made a part of this contract.* It is understood that unusually involved cases and services not scheduled will be subject to review and recommendation by Medical Service Administration to the New Jersey Regional Office of the Veterans Administration for determination of appropriate fee.

(5) Medical Service Administration will make payment to the individual physicians for services rendered on all cases in which authorizations have been issued and will in turn bill the Veterans Administration at the end of each month. Veterans Administration will remit in accordance with such bill within a reasonable time after receipt thereof.

(6) Medical Service Administration contemplates that the performance of this contract will be without profit to it and if operating results are at variance with this intention revisions will be proposed to produce such a non-profit operation.

(7) Medical Service Administration warrants that the rates charged herein are not in excess of the rates charged other persons, who are not Veterans Administration beneficiaries, for the same service.

(8) It is impossible to determine the exact or estimated amount which will be expended under this contract. However, it is understood that upon acceptance of this proposal, the Veterans Administration will issue authorizations for such services as are necessary and Medical Service Administration will carry out its undertaking hereunder.

(9) This contract shall become effective as of March 1, 1946, and may be terminated by either party by giving thirty (30) days' written notice to that effect.

(10) This contract, if mutually satisfactory, may be renewed indefinitely for periods of one (1) year each, upon notice in writing to the contractor at least sixty (60) days prior to the expiration of each period of one (1) year, and written statement from the contractor within thirty (30) days after such notification agreeing to the renewal.

(11) Medical Service Administration agrees that in performing this contract it will not discriminate against any employee or applicant for employment because of race, creed, color or national origin, and that it will include a similar provision in all of its subcontracts.

Medical Service Administration
By: NORMAN M. SCOTT, M.D. (signed)
Medical Director

Approved and Accepted:
Veterans Administration
R. C. KIDD (signed)
Director of Supplies

FEE SCHEDULE

for care rendered veterans under provisions of the Servicemen's Readjustment Act.

See paragraph 4 of contract for fee for services not included in this list.

Fees listed for surgical procedures in hospitals include up to 16 days' routine post-operative hospital care. After this, payment on medical-call basis will apply.

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I. FEES APPLICABLE ON A MEDICAL CALL BASIS AND FOR SERVICES OF ASSISTANT AT TIME OF SURGICAL OPERATION

01	First Hospital Visit	$ 5.40
02	Daily Hospital Visit	3.25
03	Subsequent Hospital Visit, same day, if approved	1.60
04	Formal Consultation, home or hospital	10.80
05	House Visit (not over 3 miles from office)	3.25
06	House Visit, over 3 miles from office (plus .75 for each mile over 3 miles from office)	3.25
07	Night House Visit, call received and visit made between 8 p. m. and 7 a. m.	6.50
08	Office Visit with treatment	3.25
09	Office Visit with treatment by specialist where specialist's care is specified by Veterans Administration	5.40
10	Surgical Assistant (payable for services rendered by private civilian physician as relates to surgical procedures listed at a fee of $50.00 or more)	10.80

II. ABDOMINAL SURGERY

To include routine after-care in hospital

101	Esophagoscopy	$ 54.00
101a	Esophagoscopy and biopsy or removal of foreign body	81.00
102	Gastroscopy	54.00
103	Liver abscess	124.20
104	Abdominal fixation for prolapse of rectum	124.20
105	Anastomosis, intestinal	135.00
106	Anastomosis, uretero-intestinal, one-stage	162.00
	Anastomosis, uretero-intestinal, two-stage	162.00
107	Appendectomy	108.00
109	Cholecystectomy	151.20
110	Cholecystotomy	108.00
111	Choledochotomy	162.00
112	Colostomy	81.00
113	Esophagus, dilatation, by means of bougies	32.40
114	Fulguration, tumor-bladder, trachea, or esophagus	48.60
115	Gastrectomy (partial)	189.00
116	Gastroenterostomy	162.00
117	Herniotomy, diaphragmatic	189.00
118	Herniotomy—ventral, inguinal, or femoral—single	108.00
118a	Herniotomy—bilateral	135.00
119	Hysterectomy, abdominal or vaginal (including or excluding removal of adnexa)	162.00
120	Intestinal obstruction, operation for	108.00
121	Laparotomy, exploratory	108.00
122	Laparotomy and drainage, general peritonitis	108.00
123	Litholapaxy	81.00
124	Meckel's diverticulum, excision of	108.00
125	Papilloma of bladder, excision by cystotomy	81.00
126	Paracentesis of abdomen	10.80
127	Paracentesis of pericardium	27.00
129	Pyelotomy, with removal of calculus	135.00
130	Pyloroplasty	162.00
131	Splenectomy	162.00
132	Tumor, abdominal, removal of	108.00
133	Tumor, gastrointestinal tract, resection	189.00
134	Ulcer, gastric or duodenal, operation for	135.00

III. AMPUTATIONS

To include routine after-care in hospital

201	Upper arm	$ 75.60
202	Forearm	75.60
203	Finger, one	21.60
204	Fingers, each additional	10.80
205	Foot	70.20
206	Hand	70.20
207	Leg	91.80

208	Thigh	97.20
209	Toe	21.60
210	Toe, each additional	10.80

IV. ANESTHESIA

301	Anesthesia, by inhalation or continuous spinal, for the first hour	$ 10.80
301a	Anesthesia, by inhalation or continuous spinal, for each additional hour, or any fraction thereof	5.40
302	Anesthesia, spinal	10.80
303	Anesthesia, intravenous	10.80
304	Intratrachial anesthesia, first hour	16.20
305	Intratrachial anesthesia, each additional hour or fraction thereof	8.10

V. DISLOCATIONS (Closed Reduction)

To include routine after-care in hospital

401	Carpal bone, one	$ 27.00
402	Carpal bone, each additional	5.40
403	Clavicle	27.00
404	Elbow	27.00
405	Finger, one	5.40
406	Fingers, each additional	5.40
407	Hip	64.80
408	Knee	32.40
409	Mandible	10.80
410	Metacarpal bone, one	16.20
411	Metacarpal bones, each additional	5.40
412	Metatarsal bone, one	16.20
413	Metatarsal bones, each additional	5.40
415	Patella	32.40
417	Rib	10.80
418	Shoulder	32.40
419	Shoulder, recurrent or habitual (non-oper.)	27.00
420	Tarsal bone, one	27.00
421	Tarsal bones, each additional	5.40
422	Thumb	5.40
423	Toe, one	5.40
424	Toes, each additional	5.40
425	Vertebra, one or more	108.00

VI. EXAMINATIONS

501	Dermatologic examination	$ 6.50
502	Electrocardiogram, with interpretation	10.80
503	Examination of ears, nose and throat (separately or together)	5.40
504	Special ear examination, including audiometric test with chart	10.80
505	Special ear examination, to include either caloric or Barany test or both, with report	10.80
506	Examination of eyes (to include either a copy of the prescription ordered or the retinoscopic correction, the fundus and field findings; the latter by chart in all cases of optic atrophy)	10.80
507	Examination of eyes with refraction, if mydriatic is used (to include copy of the prescription ordered or the retinoscopic correction, the fundus and field findings; the latter by chart in all cases of optic atrophy)	13.50
508	Combined examination of eyes, ears, nose and throat with refraction (with or without mydriatic)	16.20
509	Genitourinary examination without cystoscopy	5.40
510	Gynecologic examination	5.40
511	Complete examination of heart, including electrocardiographic interpretation	16.20
512	Physical examination of heart or lungs	5.40
513	Neurologic examination	10.80
514	Neuropsychiatric examination	16.20
516	Orthopedic examination	5.40
517	Physical examination to determine need for hospitalization	3.25
518	General routine physical examination	5.40
519	Proctoscopy or sigmoidoscopy	10.80
520	General surgical examination	5.40
521	Ventriculography, air injection through skull for diagnostic purposes (not including x-ray)	43.20

VII. COMPOUND FRACTURES

To include routine after-care in hospital

601	Carpal bone, one	$ 48.60
602	Carpal bones, each additional	16.20
603	Clavicle	54.00
604	Coccyx	54.00
605	Femur	135.00
606	Femur, when suture, plating, or nailing or extension	162.00
607	Fibula	43.20
608	Fibula, suture or plating	81.00
609	Finger, one	27.00
610	Fingers, each additional	10.80
611	Humerus	81.00
612	Humerus, suture or plating or extension	135.00
613	Malar bone	54.00
614	Mandible (wiring if necessary)	108.00
615	Metacarpal bone, one	27.00
616	Metacarpal bones, each additional	10.80
617	Metatarsal bone, one	27.00
618	Metatarsal bones, each additional	10.80
619	Nasal bones	32.40
620	Patella	64.80
621	Patella, suture or plating	108.00
622	Pelvis	86.40
623	Pelvis, suture or plating	162.00
624	Radius or ulna, or both	59.40
625	Radius, or ulna, or both, suture or plating	135.00
626	Rib, one	27.00
627	Ribs, each additional	5.40
628	Sacrum	81.00
629	Scapula	54.00
630	Skull, vault	108.00
631	Sternum	64.80
632	Tarsal bone, each	48.60
633	Tarsal bones, each additional	16.20
634	Tibia	64.80
635	Tibia, suture or plating	108.00
636	Tibia and fibula	81.00
637	Tibia and fibula, suture or plating	135.00
638	Toe, one	21.60
639	Toes, each additional	10.80
640	Vertebra, one or more	135.00

VIII. SIMPLE FRACTURES

To include routine after-care in hospital

701	Carpal bone, one	$ 32.40
702	Carpal bone, each additional	5.40
703	Clavicle	43.20
704	Coccyx	16.20
705	Femur	91.80
706	Femur, suture or plating, or extension	162.00
707	Tibia or fibula, including Potts' fracture	54.00
708	Tibia or fibula, suture or plating	135.00
709	Finger, one	16.20
710	Fingers, each additional	5.40
711	Humerus	54.00
712	Humerus, suture or plating, or extension	108.00
713	Malar bone	27.00

714	Mandible (wiring if necessary)	81.00
715	Maxilla superior (wiring if necessary)	81.00
716	Metacarpal bone, one	16.20
717	Metacarpal bones, each additional	5.40
718	Metatarsal bone, one	16.20
719	Metatarsal bones, each additional	5.40
720	Nasal bones	21.60
721	Patella	43.20
722	Patella, suture or plating	81.00
723	Pelvis	81.00
724	Pelvis, suture or plating	135.00
725	Radius or ulna, including Colles' fracture	43.20
726	Radius or ulna, suture or plating	108.00
727	Rib, one	16.20
728	Rib, each additional	5.40
729	Sacrum	54.00
730	Scapula	43.20
732	Sternum	54.00
733	Tarsal bone, one	16.20
734	Tarsal bones, each additional	5.40
735	Toe, one	10.80
736	Toe, each additional	5.40
737	Vertebra, one or more	108.00
738	Vertebra, transverse process only	10.80

IX. GENERAL SURGERY

To include routine after-care in hospital

801	Adenectomy, cervical, inguinal (minor)	$ 10.80
802	Adenectomy, cervical, inguinal (radical)	70.20
803	Biopsy	10.80
804	Breast, resection of (simple)	54.00
805	Breast, resection of (radical)	135.00
806	Carbuncle, excision of	27.00
807	Deep abscess (including ischio-rectal)	54.00
808	Superficial abscess	5.40
809	Femoral artery, ligation of	54.00
810	Fulguration of tumor, superficial	16.20
811	Ingrown toenail, excision of	27.00
812	Thyroid artery, ligation of	81.00
813	Thyroidectomy	135.00
814	Tumor or cyst, deep, removal of	27.00
815	Tumor or cyst, superficial, removal of	10.80
816	Varicose veins, injection treatment, each	3.25
817	Varicose veins, one leg, operation for	54.00
818	Varicose veins, both legs, operation for	81.00
819	Pilonidal cyst, excision of	54.00

X. JOINT RESECTIONS

To include routine after-care in hospital

901	Elbow joint, excision of	$108.00
902	Hip joint, excision of	162.00
903	Knee joint, excision of	108.00
904	Shoulder joint, excision of	162.00
905	Wrist joint, excision of	81.00

XI. CLINICAL LABORATORY EXAMINATIONS

Bacteriologic Examinations

1001	Cultural examination for fungi	$ 5.40
1002	Microscopic examination for fungi	2.15
1003	Pneumococcus typing	5.40
1004	Pus or exudate (smear)	1.10
1005	Pus or exudate, cultural exam, classification	5.40
1006	T. Pallidum (dark field)	5.40
1007	Throat culture, classification of organism	5.40
1008	Throat smear	1.10

Blood

1009	Agglutination test for typhoid, paratyphoid or undulant fever	2.15
1010	Bleeding time	1.10
1011	Blood calcium	3.25
1012	Blood chlorides	3.25
1013	Blood culture, including classification	5.40
1014	Blood platelet count	1.10
1015	Blood smear for malaria	2.15
1016	Blood typing (grouping)	1.10
1017	Carbon dioxide combining power of blood plasma	5.40
1018	Chemical examination of blood, complete, including creatinin, dextrose, urea, nitrogen, non-protein N, and uric acid	16.20
1019	Cholesterol	3.25
1020	Coagulation time	1.10
1021	Complement fixation test—gonococcus infection	3.25
1022	Complement fixation test for syphilis	3.25
1023	Complement fixation test for tuberculosis	3.25
1024	Creatinin	3.25
1025	Dextrose	3.25
1026	Total erythrocyte count	2.15
1027	Fragility test for erythrocytes	5.40
1028	Hemoglobin estimation	2.15
1029	Hydrogen ion concentration	5.40
1030	Differential leucocyte count	2.15
1031	Total leucocyte count	2.15
1032	Complete blood count, including total counts	5.40
1033	Non-protein nitrogen	3.25
1034	Occult blood	1.10
1035	Blood phosphorous	2.15
1036	Precipitation test	2.15
1037	Reticulocyte count	2.15
1038	Sedimentation rate	2.15
1039	Estimation of sugar tolerance	10.80
1040	Urea nitrogen	3.25
1041	Uric acid	3.25
1042	Van den Bergh Blood test for icterus	2.15
1043	Volume index	3.25

Feces

1040	Cultural exam of feces for causative micro-organism	8.10
1045	Fat in feces	1.10
1046	Parasites and ova	5.40

Pathologic examinations

1047	Autopsy, complete, with report, including histologic examination	54.00
1048	Tissue examination, with report	5.40

Skin tests

1049	Protein sensitization tests (series), including allergens, for purpose of establishing causative factor	27.00
1050	Tuberculin	3.25

Spinal Fluid

1051	Examination of spinal fluid for causative organism (smear)	3.25
1052	Cell count	2.15
1053	Colloidal gold reaction	3.25
1054	Complement fixation test for syphilis	3.25
1055	Cultural exam of spinal fluid, including classification of causative micro-organism	5.40
1056	Globulin test	1.10
1057	Examination of spinal fluid, including complement fixation test, colloidal gold, globulin test, and cell count	10.80
1058	Precipitation test for syphilis	3.25

Sputum

1059	Tubercle bacillus (plain smear)	3.25
1060	Tubercle bacillus (concentration method)	5.40
1061	Duodenal content for pancreatic ferments	3.25
1062	Gastric content for acidity, by histamin	8.10
1063	Gastric content for pepsin	3.25
1064	Routine chemical (including test seal with withdrawal of stomach contents)	10.80

Urine

1065	Chemical examination, routine	1.10
1066	Chemical and microscopic examination	2.15
1067	Chlorids	3.25
1068	Creatinin	3.25
1069	Culture, including classification of microörganism	5.40
1070	Hydrogen ion concentration	1.10
1071	Mosenthal test	2.15
1072	Total nitrogen	3.25
1073	Renal function test (including phenosuiphonephthalein)	3.25
1074	Tubercle bacilli	3.25
1075	Urea nitrogen	3.25
1076	Uric acid	3.25
1077	Urobilin	1.10

Miscellaneous

1078	Animal inoculation for diagnosis, with report of autopsy	10.80
1079	Preparation of autogenous vaccine	10.80
1080	Determination of basal metabolic rate	5.40

XII. MISCELLANEOUS

1101	Blood transfusion (administration only, without venesection)	$ 10.80
1102	Non-surgical drainage of gallbladder	10.80
1103	Electrocardiograms, interpretation of	5.40
1104	Hypodermociysis	3.25
1106	Injection of alcohol, trigeminal nerve	27.00
1107	Intravenous injection, exclusive of cost of drug	3.25
1108	Application of plaster cast, chest	16.20
1109	Application of plaster cast, thighs and hips	27.00
1110	Application of plaster cast, thigh and leg	10.80
1111	Application of plaster cast, torso	27.00
1112	Application of plaster cast, torso and hips	32.40
1113	Application of plaster cast, entire body	54.00
1114	Application of plaster cast, entire body in hyperextension	108.00

XIII. NEURO-SURGERY

To include routine after-care in hospital

1201	Encephalography, air injection by spinal route for diagnostic purposes	$ 27.00
1202	Brain abscess	162.00
1203	Chordetomy	162.00
1204	Gasserian gangiion, excision of	162.00
1205	Laminectomy	162.00
1206	Nerve, suture of	108.00
1207	Supraorbital nerve, injection of	16.20
1208	Neuroma, resection of	54.00
1209	Cisterna puncture, including local anesthesia and obtaining fluid	27.00
1210	Lumbar puncture, including local anesthesia and obtaining fluid	10.80
1211	Skull, decompression of	108.00
1212	Sympathectomy, cervical or lumbar	162.00
1213	Sympathectomy, periarterial	108.00
1214	Tumor of brain, operation for	216.00

XIV. NOSE AND THROAT

To include routine after-care in hospital

1301	Oral abscess (not to include dental or peridental)	$ 10.80
1302	Adenoidectomy	21.60
1303	Antrum, intranasal, drainage of	21.60
1304	Antrum, radical, operation for	108.00
1305	Cleft palate, operation for	108.00
1306	Harelip, operation for	81.00
1307	Intubation, laryngeal	27.00
1308	Laryngectomy	162.00
1309	Larynx, cauterization of	27.00
1310	Tumor of larynx, removal of	108.00
1311	Nasal polypus, removal of	21.60
1312	Nasal septum, submucous resections of	54.00
1313	Pharyngeal abscess, operation for	21.60
1314	Accessory nasal sinuses, irrigation of	10.80
1315	Ethmoid sinus, radical, operation for	81.00
1316	Frontal sinus, intranasal, drainage	54.00
1317	Frontal sinus, radical, operation for	108.00
1318	Sphenoid sinus, drainage of	54.00
1319	Tonsillar abscess, operation for	21.60
1320	Tonsillectomy	43.20
1321	Tonsillectomy and adenoidectomy	48.60
1322	Tracheotomy	54.00
1323	Turbinate bone, galvano-cauterization of	21.60
1324	Turbinectomy	27.00

XV. OBSTETRICS AND GYNECOLOGY

To include routine after-care in hospital

1401	Pregnancy, delivery only—spontaneous	$ 54.00
	Pregnancy, delivery only—low forceps	70.20
	Pregnancy, delivery only—mid forceps or version	81.00
1402	Miscarriage—to six months	21.60
1403	Miscarriage—to six months (with D & C)	32.40
1404	Miscarriage, after six months	43.20
1405	Caesarean section, vaginal or abdominal	108.00
1406	Pregnancy, ectopic (also ruptured)	135.00
1407	Bartholin's Gland, incision	10.80
1408	Bartholin's Gland, excision	32.40
1409	Urethral caruncle, removal	16.20
1410	Labial tumors and cysts, removal	27.00
1411	Atresia of vagina, correction of	54.00
1412	Perineorrhaphy	54.00
1413	Colporrhaphy, anterior	54.00
1414	Fistula, recto- or vesico-vaginal	108.00
1415	Cul-de-sac, drainage	54.00
1416	Cauterization of cervix	21.60
1417	Dilatation and curettage	32.40
1418	Tubal inflation	16.20
1419	Uterine polypi, removal	27.00
1420	Trachelorrhaphy	54.00
1421	Conization	54.00
1422	Cervix, amputation	54.00
1423	Hysterectomy, vaginal or abdominal	162.00
1424	Myomectomy	108.00
1425	Uterine flexions, etc., correction	108.00
1426	Oopherectomy	108.00
1427	Ovariotomy	81.00
1428	Salpingectomy, with or without oophorectomy or appendectomy	108.00

XVI. OPHTHALMOLOGY

To include routine after-care in hospital

1501	Cataract, needling operation for	$ 54.00
1502	Cataract, operation for	108.00
1503	Chalazion, operation for	10.80
1505	Corneal ulcer, cauterization of	27.00
1506	Extropion, operation for	54.00
1507	Entropion, operation for	54.00
1508	Enucleation of eye	81.00

1509	Foreign body, removal from conjunctiva (dissection)	16.20
1510	Foreign body, removal from conjunctiva (magnet)	10.80
1511	Foreign body, removal from cornea (dissection)	27.00
1512	Foreign body, removal from cornea (magnet)	21.60
1513	Foreign body, removal from eyeball (deep)	108.00
1514	Curettage of lids for trachoma	10.80
1515	Hordeolum, operation for	5.40
1516	Iridectomy	81.00
1517	Lacrymal duct, dilatation of	5.40
1518	Lacrymal sac, excision of	64.80
1519	Pterygium, operation for	43.20
1520	Ptosis, skin and tarsal resection, operation	81.00
1521	Strabismus, operation for	86.40

XVII. ORTHOPEDIC

To include routine after-care in hospital

1601	Arthroplasty, major joint	$162.00
1602	Bone graft (long bone)	162.00
1603	Bone plate, removal of	37.80
1604	Cartilage of condyle of femur, removal of	81.00
1605	Semilunar cartilage, removal from joint	81.00
1606	Club foot, operation for	81.00
1607	Coccyx, excision of	54.00
1608	Hallux valgus, operation for	54.00
1609	Hallux valgus, bilateral, operation for	81.00
1610	Hammer toe, operation for	54.00
1611	Osteomyelitis, long bones radicle operation	81.00
1612	Sequestrum, removal of (deep)	54.00
1613	Sequestrum, removal of (superficial)	16.20
1614	Tenorrhaphy, one	37.80
1615	Tenorrhaphy, each additional	16.20
1616	Tenotomy	37.80
1617	Torticollis, operation for	81.00

XVIII. OTOLOGY

To include routine after-care in hospital

1701	Mastoid, simple operation	$108.00
1702	Mastoid, radical operation	135.00
1703	Ossiculectomy	108.00
1704	Paracentesis	10.80
1705	Polypus, removal of	27.00
1706	Lateral sinus, drainage	162.00

XIX. PROCTOLOGY

To include routine after-care in hospital

1801	Anal fissure, operation for	$ 27.00
1802	Carcinoma of rectum, excision of	162.00
1803	Fecal fistula, abdominal, operation for	81.00
1804	Fistula, rectovaginal, operation for	108.00
1805	Fistula, urethral, operation for	64.80
1806	Fistula, vesico-vaginal, operation for	108.00
1807	Fistula-in-ano, operation for	54.00
1808	Hemorrhoidectomy	67.50
1809	Stricture of rectum, operation for	75.60
1810	Whitehead's operation	81.00

XX. THORACIC SURGERY

To include routine after-care in hospital, except 1919

1901	Bronchoscopy	$ 54.00
1902	Bronchoscopy and biopsy or removal of foreign body	81.00
1903	Thoracoscopy	54.00
1904	Thoracotomy, incision and drainage, including rib resection	64.80
1905	Subphrenic abscess	129.60
1906	Apicolysis	108.00
1907	Lobectomy	162.00
1908	Oleothorax	54.00
1909	Paracentesis of thorax, diagnostic	5.40
1910	Phrenic nerve operation	54.00
1911	Pneumolysis, extra or intrapleural	108.00
1912	Pneumonectomy	162.00
1913	Pneumonotomy, cautery	108.00
1914	Pneumoperitoneum, first induction	16.20
1915	Pneumoperitoneum, refills	10.80
1916	Artificial pneumothorax, first induction	16.20
1917	Artificial pneumothorax, refills	10.80
1918	Scaleniotomy	54.00
1919	Thoracotomy, without rib resection	43.20
1920	Thoracoplasty, each stage	135.00

XXI. SURGICAL CARE OF TRAUMATIC WOUNDS

2001	Incised wound, office procedure	$ 6.50
2002	Lacerated wound	10.80
2003	Punctured wound	6.50

XXII. UROLOGY

2101	Genito-urinary examination with cystoscopy	$ 27.00
	Genito-urinary examination with retrograde pyelogram	37.80
2102	Prostatic abscess, incision and drainage	54.00
2103	Circumcision (infant)	10.80
	Circumcision (adult)	16.20
2104	Cystotomy, suprapubic	54.00
2105	Epididymectomy	70.20
2106	Hydrocele, aspiration of	5.40
2107	Hydrocele, operation for	54.00
2108	Nephrectomy or Nephrotomy	162.00
2109	Nephropexy	108.00
2110	Orchidectomy	54.00
2111	Prostatectomy, perineal	162.00
2112	Prostatectomy, suprapubic (one or two stages)	162.00
2113	Prostatic resection, transurethral	108.00
2114	Ureteral stone, removal of	135.00
2115	Urethral stricture, dilation of	5.40
2116	Urethrotomy, external	81.00
2117	Urethrotomy, internal	54.00
2118	Varicocele, operation for	54.00

XXIII. SPECIALIST'S FEES

(Routine treatment and advice)

2201	Psychotherapeutic conference	$ 7.55
2202	Psychometric testing	8.65
2203	Intravenous Sodium Amytal	10.80
2202	Electro-encephalography	21.60
2205	Electric Shock Treatment	16.20
2206	Ophthalmologic examination	5.40
2207	Nose and Throat	5.40
2208	Ear	5.40
2209	Dermatologic	5.40
2210	Orthopedic	5.40
2211	Neurologic	5.40
2212	Genito-Urinary	5.40
2213	Surgical	5.40

XXIV. X-RAY

2301	Abdomen, flat plate	$ 10.80
2302	Ankle joint, ant.-post. and lat. views	9.70
2303	Arm, humerus, ant.-post. and lat. views	10.80
2304	Bladder, with injection, ant.-post. and lat. views	16.20
2305	Chest, survey film	8.10
2306	Chest, for pulmonary, cardiac, or rib fracture, diagnosis, stereo	16.20
2307	Chest, fluoroscopic	5.40
2308	Colon, by barium enema	21.60
2309	Clavicle, ant.-post. and lat. views	9.70
2310	Elbow, ant.-post and lat. views	9.70
2311	Encephalography	16.20

2312	Encephalography, including preliminary skull	32.40
2313	Esophagus (only)	16.20
2314	Finger	5.40
2315	Fistulae, contrast study	16.20
2316	Feet, ant.-post. and lat. views	9.70
2317	Forearm, radius and ulna ant.-post. and lat. views	10.80
2318	Foreign body in eye, location of (fragment charted in three planes and its dimensions ascertained by method of Sweet or equivalent)	27.00
2319	Gallbladder, Graham technic	27.00
2320	Gallbladder, G. I., barium enema	77.75
2321	Gastro-intestinal tract, complete x-ray study including fluoroscopy	43.20
2322	Gastro-intestinal tract by barium meal and enema	54.00
2323	Hand, ant.-post. and lat. views	9.70
2324	Heart, single teleoroentgenogram	14.05
2325	Hip joint, ant.-post. and lat. views	12.95
2326	Kidneys, right and left for comparison	14.05
2327	Kidney, ureter, and bladder	14.05
2328	Knee joint, ant.-post. and lat. views	9.70
2330	Leg, tibia and fibula, ant.-post., and lat. views	9.70
2331	Lipoidal injection for bronchiactases, etc. (including roentgen)	27.00
2332	Mammary gland study	17.30
2333	Mandibles, each	11.90
2334	Mastoids	16.20
2335	Mastoids, including petrous pyramids	16.20
2336	Maxilla and facial bones	14.05
2337	Myelography	24.85
2338	Neck for soft tissue	12.95
2339	Nose	11.90
2340	Optic foramina	16.20
2341	Pelvis, ant.-post. and lat. views	14.05
2342	Pregnancy, with measurements	21.60
2343	Pregnancy, without measurements	13.50
2344	Pyelography, intravenous	28.90
2345	Pyelography, retrograde	20.00
2346	Sella Turcica	13.50
2347	Semi-lunar cartilage, both knees	17.30
2348	Shoulder girdle	12.95
2349	Sialography (without medium)	14.05
2350	Sinuses, paranasal	13.50
2351	Skull	20.50
2352	Smith-Peterson nail	34.55
2353	Spine, cervical ant.-post. and lat. views	15.10
2354	Spine, dorsal	15.10
2355	Spine, lumbar-sacral, with coccyx	17.30
2356	Spine, entire	45.90
2357	Stomach and duodenum only	30.80
2358	Stomach, duodenum and gallbladder (dye)	45.90
2359	Teeth, single	2.15
2362	Teeth, complete (periapical examination)	16.20
2363	Thigh, femur, ant.-post. and lat. views	11.90
2364	Thorax, ribs	13.50
2365	Toe	5.40
2366	Urethro-cystography	16.20
2368	Ventriculography	22.70
2369	Ventriculography, including preliminary skull	35.65
2370	Wrist	9.70

XXV. FLUOROSCOPIC AND GENERAL

2401	Reduction of fractures	$ 5.40
2402	Foreign body detection	5.40
2403	Foreign bodies in esophagus or respiratory tract	10.80
2404	Portable examination in hospital—add	5.40
2405	Fluoroscopic—chest or abdomen	5.40

XXVI. INTERPRETATION OF ROENTGENOGRAMS

2501	Bones and joints, plain ant.-post. and lat.	$ 5.40
2502	Chest for pulmonary diagnosis, plain or stereo	5.40
2503	Gastrointestinal series	5.40
2504	Genito-urinary tract	5.40
2505	Kidney films	5.40
2506	Skull, following ventriculography or encephalography	5.40

Memorial Statue to Dr. McBride

The people of Paterson are preparing to erect a statue of Dr. McBride to be placed in front of their City Hall as a permanent memorial to this distinguished citizen. However, Dr. McBride was not only a Patersonian; he was a brother physician and the medical profession want to take part in this tribute. The Trustees of The Medical Society of New Jersey are urging every member of this Society to make a contribution. Your contribution should be sent to "The Dr. McBride Memorial Fund", The Medical Society of New Jersey, 315 West State St., Trenton 8, N. J.

It is hoped that Organized Medicine's share in this memorial will be substantial enough to symbolize the relatively large rôle which the practice of medicine always played in Dr. McBride's busy and useful life.

Medical Commissions in Regular Army

March 1 is the deadline for physicians who are interested at this time in securing a commission in the regular Army. The Surgeon-General announces that under provisions of the recently enacted Public Law 281, policies have been established that will make the Corps more attractive to the practitioner. Emphasis will be on professional rather than administrative details, specialists will be afforded opportunity to train for Board examinations and credit will be given for the applicant's age in determining the grade of appointment. Physicians over the age of 37 will be eligible for appointment in the grade of Major and between the ages of 28 and 36 for commission in the rank of Captain. Applications should be sent to the Army Adjutant-General, Washington 25, D. C.

ORIGINAL ARTICLES

THROMBOSIS OF THE BASILIC, AXILLARY AND SUBCLAVIAN VEINS, OF UNDETERMINED ORIGIN

Louis A. Eigen, Captain, M.C., Army of the U. S.

Reports of primary thrombosis of the basilic, axillary and subclavian veins are few. The occurrence of this condition may be more frequent than is indicated by the sparsity of case reports. It is only since the introduction of venography and its more frequent use, that reports of primary thrombosis of the axillary and subclavian veins are finding their way into medical journals with increasing frequency.[1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12] There are almost as many theories, attempting to explain the mechanism of thrombus formation in veins as there are contributors to this subject. Matas has covered many of these theories, and cited about one hundred cases, which he was able to find in the literature, in his thorough and outstanding paper which appeared in 1934.[3]

A listing of the more common theories, with regard to the cause of this condition, is interesting and instructive, and indicates that the mechanism of thrombus formation is not the same in every case, or that we have not yet arrived at a satisfactory explanation to cover all cases. John Homans said recently in this regard, ". . . one must not be ashamed of setting up an hypothesis which can hardly be proven, and of taking false steps at times, provided the main line of thought is productive. Progress can be made and false steps retraced as they are noticed." Trauma of the intima of the venous wall seems to be the factor which is common to all or most of the theories. Following is a brief summary of the more common theories found in the literature:

1. Phlebitis is due to sudden stretching and compression of the vein. Schroetter—quoted by Pelner and Cohn.[4]

2. Rupture of the subclavius-axillary valve, in the vein under the subclavius muscle, due to increase in venous pressure, by the sudden stretching of the subclavius muscle, with the arm in abduction. Gould and Patey.[13]

3. Damage to endothelium caused by distention of the axillary veins resulting from respiratory effort. Godenot.

4. The intima is injured as a result of pressure on the vein from the coracoid ligament and subclavius muscle—when the arm is extended and abducted. Lowenstein.[14]

5. Irritation of the perivenous sympathetic plexus, resulting in venospasm and thrombus formation. Cottalorda (quoted by Matas and by Pelner and Cohn).

6. Local venospasm is caused by a stimulation of the sympathetic neurons—being the end result of a reflex disorder. The irritative stimulus passes up the afferent or sensory nerve, in association with a somatic nerve, into the cord; the outgoing sympathetic (vasoconstricting) impulses are received or initiated here. This results in a vasoconstriction of the blood vessels. John Homans.[15]

7. Chemical changes in the blood, caused by catabolites of abnormal metabolism on top of and in addition to whatever mechanical factors may be involved. Rosenthal and Lahr (quoted by Kramer).[16]

8. Constriction of the subclavian vein occurs below the head of the humerus and against the subscapularis muscle, in hyperabduction of the arm, in some cases. Veal.[8]

9. Stimulation of sympathetic nerve fibers results in a vasospasm of all corresponding blood vessels (both large and small). This stimulation is a reaction to a great many types of peripheral injuries. Baum.[17]

10. Demonstration of wide fluctuations in axillary venous pressure in case of abducted arm, during forced respirations. Veal and McFetridge.[7]

11. Thrombus formation resulting from compression of the subclavian vein produced by a posterior and cephalad rotation of the shoulder girdle, without abduction of the arm. J. J. Sampson.[5, 6]

These theories are of interest as a basis for speculation of causative factors in the following case report. As will be seen, they do not explain the syndrome presented by our patient. The usual patient is a young, vigorous male who develops thrombosis in the arm which is most commonly used (on the right side in a right-handed individual, and on the left side in a left-handed individual). In practically every case thus far reported there has always been the history of a very definite incident or time of onset.

CASE REPORT

A white female, aged 37, weighing 110 pounds, and five feet tall, was admitted to St. Anthony's Hospital in Las Vegas, New Mexico, April 20th, 1943, about three months after the onset of her present illness. Her chief complaints on admission were:

1. *Precordial pains* which radiated to her left breast, left shoulder and down her left arm, but did not appear to take any definite course or follow any single pattern. They were uninfluenced by exertion. Position did not appear to have any effect nor did the time of day, even though the temperature between night and day varied by as much as sixty degrees. It might be stated here that the altitude of Las Vegas, New Mexico, is about 7000 feet above sea level and wide temperature variations are usual.

2. *Dysphagia,* of mild to moderate severity. This was inconstant and was brought on by liquids, soft or solid foods.

3. *Dyspnoea,* which was somewhat evanescent and mild in character. It would come on during the night as readily as during the day and appeared to be unrelated to the time of appearance of the precordial pains.

4. Frequent feeling of tightness in the upper part of chest, lasting for from two minutes to one hour.

5. *Moderate swelling* of the left side of neck and left shoulder. This swelling did not appear to be related to any exertion, but increased and decreased quite often and at irregular intervals varying from five minutes to as long as twenty-four hours. It never disappeared entirely.

Present Illness: Patient was feeling perfectly well until the time that she first noted a feeling of tightness in her left hand. The tightness persisted and in about ten days the fingers of this hand became slightly numb and she experienced a peculiar pricking sensation. About a week later the hand began to swell and slowly the swelling increased, spreading to the wrist and the forearm. Finally the shoulder, neck, and chest were involved. About five weeks after the appearance of symptoms she consulted a physician who found a moderate degree of pitting edema of the entire area, some cyanosis and slight persistent dilation of the superficial veins of this extremity. He treated her symptomatically for about three weeks. Her symptoms subsided spontaneously but there was never complete recovery, there was a tendency to recurrence. Subsequent episodes were less severe than the preceding ones. About eight weeks after the onset of her present illness she noted that "—all the veins stood out on the back of my hand." She then came under our observation. At no time did she have any fever.

Past Medical History: Measles, chicken pox and mumps before the age of seven years. T & A at twenty years. Laparotomy at twenty-one years. She said that her right ovary, right fallopian tube, appendix and a tumor, about the size of an orange, were removed. At seventeen years of age she was secretly married and contracted syphilis. She received immediate intensive treatment for two and a half years and was pronounced entirely cured.

Family History: No history of familial or inheritable disease was elicited.

Physical Examination: An alert, coöperative, intelligent, white adult female, lying comfortably in bed, 37 years of age, who looked ten or twelve years younger.

Eyes: Negative. Pupils were round, regular and equal, reacting normally to light and in accommodation. Blood vessels of the eye grounds were normal. There were no abnormal findings.

Ears: Normal.

Nose: Left middle turbinate was moderately swollen and boggy.

Throat: Not unusual, except that the uvula appeared to be shrunken.

Mouth: Good hygiene.

Teeth: None missing. There were ten fillings in the molars, but all were in good condition. X-ray of teeth revealed neither periapical abscesses nor absorption of bone.

Neck: Left supraclavicular fossa was entirely obliterated. The angle between the neck and shoulder was filled in with edematous tissue, which was somewhat rubbery in consistency. The overlying skin was stretched, but not discolored. Thyroid was slightly enlarged to palpation. The anterior and posterior cervical nodes were discrete, and felt as though they were about one-quarter inch in diameter. No supra or infraclavicular nodes could be felt. Axillary nodes were easily palpable on the left, but not on the right. There were no palpable nodes anywhere else.

Chest: Somewhat flat, but quite normal other-

wise. Respiratory movements were free and equal. Both lung fields were resonant throughout and no adventitious sounds were heard. Both breasts were about equal in size, shape, position, color, consistency and appearance. They were virginal in type, with small flat nipples which were not retracted. There were no nodules in either breast. The skin was smooth and freely movable. The superficial venules of the skin of the left breast were slightly dilated.

Cardio-vascular System: Heart and mediastinum were not enlarged to percussion. No arrythmias or extra systoles were heard. There was no pulse deficit. Arterial blood pressure was essentially the same in both arms, 115/75-70 (right), 118/75-75 (left). The pulse was of good quality and regular. The peripheral arteries were easily compressible and soft.

Veins: When both hands were raised to the horizontal position the veins on the dorsum of the right hand collapsed almost at once, while those in the left hand remained full for 80 seconds. This was tried with the arms in several different positions (anteriorly, sidewards, etc.). The results were invariably the same when the horizontal position was reached. The dilatation of the venules in the skin of the left breast also involved the venules of the skin of the left anterior thorax as far back as the posterior axillary line. Below, it gradually disappeared, at about the level of the seventh rib. The veins were not tender nor painful. There was no discoloration over the involved veins nor did they feel like cords.

Abdomen: Flat—no pain or tenderness. No viscera or masses palpable.

Gastro-intestinal System: Appetite very good, despite dysphagia. No symptoms of indigestion. Bowels had always been moderately constipated. No hemorrhoids.

Genito-urinary System: Menstrual history—Began at 14, no dysmenorrhea, period occurred every 28 days and lasted 3-5 days, flow was moderate in amount. Last menstruation was normal. No dysuria, no frequency, no urgency, no burning. Pelvic examination did not show any abnormalities nor any chronic infection.

Skin: Generally clear, except for a thin scar, about five inches long, over the lower right rectus muscle—the result of a previous laparotomy.

Extremities: No abnormalities, except those previously described affecting the left upper extremity.

Neurological Examination: No pathological reflexes could be elicited. No sensory disturbances, except those previously described involving the left hand. There was, however, a moderate generalized hyperreflexia.

Laboratory Findings:

Red blood count	4,890,000
Hemoglobin	92% (Sahli)
White blood count	6150, 9850, 7000
Differential	
Polymorphonuclear leucocytes	88%, 60%, 64%
Small lymphocytes	10%, 40%, 31%
Myelocytes	2%, 0, 2%
Eosinophiles	0, 0, 3%
Sedimentation Rate	18 mm/hr. 4 mm./hr.

Sugar tolerance: (100 grams sugar ingested)

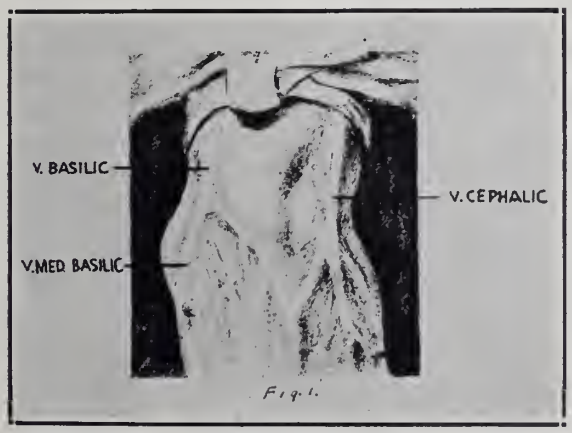


FIGURE 1

Shows the normal surface anatomy of the involved veins.



FIGURE 2

X-ray of the left shoulder region, taken immediately after injection of 30 cc. of Diodrast into basilic vein. Basilic vein is entirely occluded. The cephalic vein and extensive collateral circulation from it are shown.

	Blood	Urine		
		Sugar	Acetone	Diacteic Acid
Fasting	72 mg./100 cc.	0	0	0
½h after glucose	400 mg./100 cc.	½%	0	0
1h after glucose	234 mg./100 cc.	0	0	0
2h after glucose	150 mg./100 cc.	¼%	0	0
3h after glucose	60 mg./100 cc.	0	0	0

Sugar tolerance was repeated, with no change in results.

Blood Wassermann and Kahn were negative.

Spinal Fluid—Wassermann and Kahn were negative.

Basal Metabolic Rate was minus 1.2%.

Urine—Negative, except that on two occasions acid fast stain (Ziel-Nielson) was positive for acid fast bacilli, simulating tubercle bacilli (4-13 per high power field). Clinical findings did not support the diagnosis of tuberculosis. Extensive fluoroscopic and Roentgen ray studies of neck of thoracic cage, of the mediastinum, of the heart and of the lungs failed to reveal any pathology in these structures.

Venography: The patient was placed on her back on the x-ray table. Thirty cubic centimeters of Diodrast were injected into the cephalic vein of the left arm, quite rapidly, and the x-ray was taken as the last two cc.'s were being injected. Figure 2 is a reproduction of this roentgenogram. Forty-five seconds later another Roentgenogram of this same area was taken and even in so short a space of time, the dye had entirely left the veins, and the veins were consequently no longer visualized. Exactly the same technique was repeated on the right side. Figure 3 is a reproduction of the first Roentgenogram taken on the right side.

Electro-Cardiogram: Showed nothing abnormal, except a very slight prolongation of the P-R interval in leads 1 and 2 (0.22 seconds).

Clinical Course of Patient, While Under Observation and Treatment: The arm was put at more or less complete rest. She was kept in bed for eighteen days. No specific treatment was instituted. She received no medication except mild sedation (phenobarbital). Her symptoms gradually subsided and she showed a remarkable degree of improvement during the time that she was under my observation. I was transferred to another station so have been unable to follow the course of this patient's illness further.

DISCUSSION

Our patient was a 37-year-old white female, whose husband was an officer stationed at Camp Luna, New Mexico. She had been living at a nearby hotel for several months prior to the onset of the present illness. She had not participated in any unusual type of physical exertion, not even any of the usual household chores. She was right-handed in every respect. Her first symptoms occurred spontaneously.

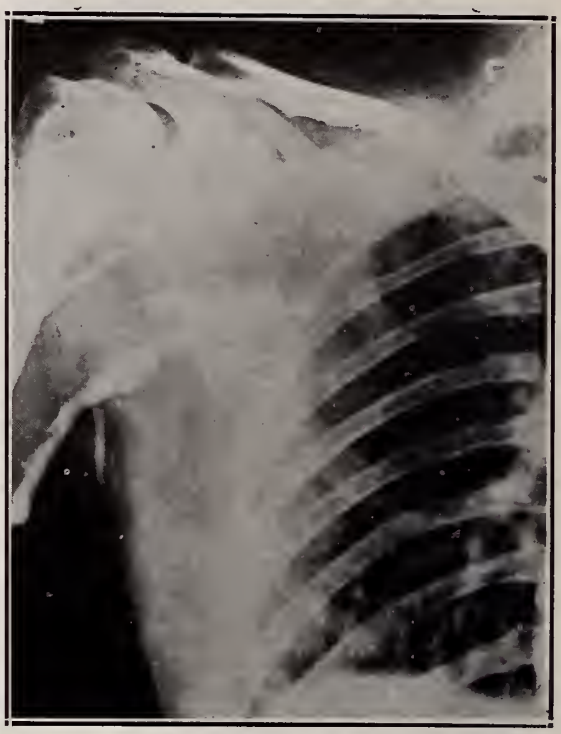


Figure 3

X-ray of the right shoulder region, after injection of 30 cc. of Diodrast into basilic vein.

Obviously no theory so far put forward offers a satisfactory explanation for the etiology of the thrombus formation. Here the basilic as well as the axillary and subclavian veins were involved, and to a greater degree than has apparently been the case in most of the reported cases.

The two unusual laboratory findings should be mentioned at this time: the bizarre sugar tolerance curve (faulty metabolism) and the tubercle bacilli in the urine. Their significance and relationship to the mechanism of thrombus formation in this case is vague and will not be further discussed, except to predict a possible recurrence, perhaps at some other point in her venous system, that is, if they have anything to do with it at all.

Diagnosis was established by means of x-ray, in conjunction with the simultaneous use of a radio-opaque contrasting substance injected into the vein. The developing collateral circulation about the left shoulder may explain, in part, the fluctuating character of

the patient's symptoms, with their gradual relief.

Tumor, primary or secondary to a primary focus in the liver, pelvis or thoracic viscera, should be mentioned as an etiologic possibility. This was thought of in this case, but nothing was found to substantiate it.

SUMMARY AND CONCLUSIONS

A case of obliteration of the venous circulation which is due to thrombophlebitis of unknown origin, in a middle-aged woman is presented. Some of the literature relating to thrombosis of the axillary vein has been reviewed. The thrombosis occurred on the left side in a right-handed individual.

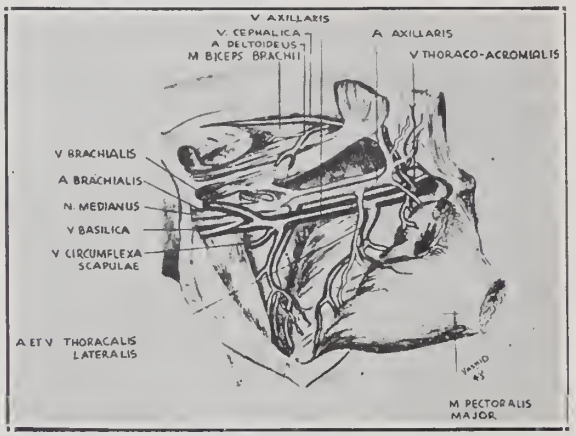


FIGURE 4
Shows relationship of vessels, etc., at shoulder region.

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ANALYSIS OF COLDS IN INDUSTRY

J. H. KLER, M.D., New Brunswick, N. J.

Colds are responsible for more than one-third of the total number of days lost in American industry. They cause a loss of 100 million working days each year. There is a definite pattern to the incidence of colds, with the highest peak in December (or December-January) and a lesser peak in October. July is the month of lowest incidence of colds. Sudden drops in temperature are followed by rises in the incidence and in the severity of colds. Both incidence and severity are much greater among office workers than among factory workers and greater among women than among men. A majority of the colds in women appeared at the time of the menstrual period. There is decreasing incidence of colds with increasing age. The severity of colds increases with age. There are fewer colds in air conditioned plants. The incidence of colds is highest in drafty places. More colds start on Monday than on any other day of the week. This is especially true of colds among men. Posture is an important factor in that the incidence and the severity of colds are lowest among those whose work necessitates walking about most of the time. Early therapy seems to be of greatest value.—Archives of Otolaryngology, June, 1945.

THE TREATMENT OF THE DIARRHEAS

J. GERENDASY, M.D., Elizabeth, N. J.

In the management of the diarrheas diligent search for the cause is of first importance. A number of these are enumerated in Table 1. Diarrhea is an urgent symptom and its effects on the individual are many and profound, depending on the severity and duration of the attack. During the active phase, therapy is indicated to overcome dehydration and to prevent toxemia and malnutrition. Dehydration depletes the body of water and electrolytes, especially sodium. Toxemia is the consequence of disturbance in the acid-base equilibrium whereby the loss of basic (sodium) bicarbonate from the enteric secretions results in acidosis. Malnutrition is caused by inability to absorb essential foods, including vitamins and mineral salts, such as potassium, calcium and magnesium.

A factor of great importance in severe diarrhea is the rapid fall of plasma volume and an increase in the hemoconcentration reading of the red blood cells. Plasma protein exercises a major rôle in maintaining the balance between tissue fluid and the circulating blood. In effect, it attracts and holds fluid in the blood stream and thus prevents dehydration, maintains kidney function and prevents shock. The introduction of large quantities of crystalloid solutions (e. g. Hartmann's) into the blood stream causes loss of plasma protein, impairs renal function and further increases azotemia and acidosis. To obviate this, blood protein determinations should be done regularly and the quantity of saline solutions limited to the acute phase.

Specific treatment of the diarrheas, therefore, depends on three factors: Restoration of (1) lost electrolytes, (2) of plasma volume, and (3) of the intracellular cations K, Ca, Mg, etc. In ordinary cases, 3000 to 3500 cc of Ringer's solution with or without 5 per cent glucose (the latter depending on the severity of toxemia) alternating with blood plasma will supply these deficiencies. If acidosis is severe, Hartmann's lactated infusion is administered in the same quantity. It is preferable to a solution of sodium bicarbonate. The protein requirement is usually met with 30 to 40 grams of protein administered as 400 to 600 cc of 15 per cent amino-acid solution. Usually not over 200 cc are added to each litre of intravenous solution. As soon as feasible, a high protein diet with the addition of concentrated proteins (aminoids) is given by mouth.

The general principles governing the treatment of all diarrheas, whether functional or organic, may be summarized as follows: (1) General body rest, (2) diet, (3) specific measures, (4) drug therapy.

1. *Rest* in bed is important. It permits a period of starvation, usually 24 to 48 hours. It decreases peristalsis, facilitates parenteral treatment and conserves energy and nutrition. If the diarrhea persists over 48 hours despite rest,

TABLE 1

CLASSIFICATION OF THE DIARRHEAS

(modified from Kantor)

A. FUNCTIONAL

1. Simple (dietary indiscretion)
2. Gastrogenic (absence of free HCL)
3. Putrefactive
4. Fermentation
5. Endocrine
   a. Thyroid
   b. Adrenal
6. Pancreatic
7. Sprue and pellagra
8. Psychogenic (nervous)
9. Allergic (milk)

B. ORGANIC

1. Toxic
   a. Mercury
   b. Arsenic, etc.
2. Infectious
   a. Specific or primary
      (1) Bacillary
          dysentery
          tuberculosis
          ulcerative colitis
      (2) Protozoal
          amebic
          flagellates
      (3) Non-specific
          tumor, polyps
          malignant growth
          Hodgkin's disease

diet and sedation, the diarrhea is probably of organic origin.

2. *Diet* should fulfill the following conditions: It should be (a) non-stimulating and non-irritating to the bowel; (b) easily digested, leaving little residue; (c) should have sufficient calories, proteins and vitamins after control of diarrhea, and (d) should eliminate milk. This is contrary to all prescribed treatment. However it is an important precept to be followed temporarily in some cases; permanently in others. See tables 2, 3 and 4.

3. *Specific Measures:* (a) Parenteral (intravenously preferred) fluids and salts for 2 or 3 days. (b) Plasma protein, 15 to 30 grams daily or more. In patients with hemorrhage, blood transfusions (200 to 250 cc) are repeated every 2 or 3 days. (c) Heat to abdomen (turpentine compresses) every 2 or 3 hours.

4. *Drug Therapy:* (a) Antispasmodics such as tincture of belladonna (10 minims t.i.d.) or deodorated tincture of opium (10 minims every 4 hours). (b) Sedation—phenobarbital gr. ½ t.i.d.; or morphin gr. ¼—atropin gr. 1/150. This is especially good to promote sleep. (c) Calcium gluconate 10 cc; 10 per cent intravenously (to replace calcium loss and relieve intestinal spasm). (d) Large doses of vitamins (B complex, haliver oil, ascorbic acid, nicotinic acid, iron). (e) In indicated cases, sulfasuxidin, sulfaguanidin, sulfathiazol—15 grains every 4 hours, after initial 30 grain dose. (f) The bismuth salts, silver nitrate, and tannic acid are mentioned only to be condemned. Kaolin (Kaomagma) is occasionally beneficial. Dose is half ounce every four hours.

However, unless the fundamental principles outlined in the first three paragraphs are kept in mind, the treatment of the diarrheas will result in failure.

TABLE 2

FIRST STAGE DIET

One to Three Days

8 a. m.	Weak tea, sugar; no milk.
12 noon.	Weak tea, with sugar—kitchen made gelatine with sweet cream.
3 p. m.	Clear broth.
6 p. m.	Weak tea, with sugar—kitchen made gelatine with sweet cream.
9 p. m.	Clear broth.
At bedtime, kitchen made gelatine with sweet cream.	

TABLE 3

SECOND STAGE DIET

Three to Ten Days

8 a. m.	Weak tea, sugar.
	Arrowroot gruel, Uneeda crackers with butter, kitchen made gelatin.
10 a. m.	Boiled rice, Uneeda crackers with butter, kitchen made gelatin.
12 noon.	Cornstarch or tapioca pudding.
	Weak tea—Uneeda crackers with butter, kitchen made gelatin.
3 p. m.	Weak tea—Uneeda crackers with butter, kitchen made gelatin.
	Arrowroot (or tapioca) gruel.
6 p. m.	Clear broth.
	Boiled rice—Uneeda crackers with butter, kitchen made gelatin.
9 p. m.	Clear broth.
	Cornstarch (or tapioca) pudding.
	Uneeda crackers with butter, kitchen made gelatin.

TABLE 4

THIRD STAGE DIET

Tenth to Twenty-first Day

8. a. m.	Strained orange juice
	Arrowroot (or tapioca) gruel
	White bread, butter, weak tea
10 a. m.	Clear broth
12 noon.	Clear broth
	Boiled breast of chicken
	Mashed potatoes, creamed
	Pureed carrots
	Cornstarch (or tapioca) pudding
	White bread, butter
3 p. m.	Weak tea
6 p. m.	Clear broth
	Soft boiled egg
	Cottage cheese
	Baked squash
	Boiled rice, milk and sugar
	White bread, 2 slices, butter
9 p. m.	Cornstarch (or tapioca) pudding

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TWO CASES OF OZENA CURED BY PICKRELL SOLUTION

RALPH J. VREELAND, M.D., Paterson, N. J.

The condition Ozena being what it is, a thing of misery and disgust to the patient and repulsion to those who must associate with the patient, I feel that I should report the unusual results obtained in two cases which I have seen recently.

The first was a woman 38 years of age who appeared because of an acute abscess in her ear.

When I went to examine her nose she remarked, "Doctor, you are going to see a terrible condition." She said, "Doctor, I would welcome any suggestions but I am not very optimistic."

Not having made any progress in this condition over a period of 25 years, I could not offer her the least bit of hope. I gave her a prescription for a medicine other than Pickrell Solution.

Later she returned with an otitis media, and upon inquiring whether she had used the spray I had prescribed for her, she answered in the negative that she had been unable to get it. I then gave her a prescription for Pickrell Solution to be used as a spray four times a day. At the time I forgot to record the fact upon her card.

At a subsequent visit for another ear infection my amazement knew no bounds when upon looking into her nose I saw it completely free of crusts and discharge and the tissue of a healthy pink color. Watching my expression, she said, "Doctor, isn't that wonderful." Having forgotten what I had prescribed for her, I was very thankful that the patient herself remembered the name.

It just so happened that at this time I was treating another woman, age 60, with a most advanced case in which I was making no headway. This woman was sent to me by her husband, whose life was miserable because of the odor. Following the same treatment this woman's condition has cleared up just as satisfactorily as the other patient's, and if I needed any proof it was furnished by a visit from her husband thanking me for what I had done.

In view of the result of these two cases there is no question of the therapeutic value of this agency. No credit is claimed because of the absolutely accidental means by which it was discovered.

INDUSTRIAL MERCURY POISONING

LT. COMDR. LEON LEWIS, Newark, N. J.

A specialized manufacturing industry is responsible for the supply of much of the tungsten, molybdenum and tungsten-molybdenum wire and rod used in the electrical and radio industries. The process of heat treating these metal products involves the use of metallic mercury and introduces the occupational hazard of mercurialism.

Acute and chronic industrial mercurialism are not to be confused with acute poisoning by ingestion of mercurial salts. Acute industrial intoxication is largely a disease of the oral mucous membrane. Chronic mercurialism is a disease of the nervous system with characteristic manifestations and frequently unfavorable prognosis.

Sanitary engineering to prevent toxicity from mercury involves careful and controlled housekeeping, design of equipment to prevent accumulation of mercury and to promote collection of spillage, ventilation to insure a minimum concentration of mercury in the air and housing of apparatus within hoods which are forcibly exhausted. Supervised personal hygiene of workmen, preëmployment examination and frequent medical observation are also essential for the prevention of morbidity.

In the treatment of mercurialism, removal from exposure is the first essential. Dental care is important in all cases showing gingivitis and stomatitis and is usually all that is required in early acute cases. The treatment of chronic mercurialism is largely empirical and consists of symptomatic and supportive measures.—J. A. M. A., Vol. 129, No. 2, p. 123.

STATE ACTIVITIES

TRUSTEES' MEETING

Regular meeting of the Board of Trustees was held 2:00 p. m., Sunday, January 27, 1946, at the State Society Headquarters, Trenton. Present were: Dr. Norton, Chairman, who presided, Dr. Alexander, Dr. Stahl, Dr. Londrigan, Dr. Dodd, Dr. Green, Dr. Fithian, Dr. Coleman, Dr. Young, Dr. Costello, Dr. Hornberger and Dr. Schaaf. Also present upon invitation: Dr. Hollinshed, Dr. Decker, Dr. Pigott, Dr. Cosgrove, Dr. Scott, Dean Miller, Mr. Mann and Professor Chaffey. Drs. Hawkes, Lee, Crowe, North and Scammell were excused. Minutes of the October 21 and December 16, 1945, meetings were approved.

GRADUATE EDUCATION COMMITTEE

Dr. Decker, Chairman of the Committee on Graduate Education, presented Dean Miller, Mr. Mann and Professor Chaffey of Rutgers University, who had previously met with his Committee. Dr. Decker reported that the proposal to Rutgers University for the establishment of a graduate course for general practitioners had been accepted by the University. A communication from Dean Miller was read authorizing the granting of a certificate from Rutgers University to physicians completing the course.

The Committee recommended approval of this program and also suggested that the Committee on Graduate Education consist of five members, to be appointed for five years, and that the appointments be staggered so that one term expires each year.

The Committee, at the direction of President Alexander, will draw up an amendment to the By-Laws to accomplish this suggestion. This amendment will also include a provision for the appointment by the President of advisers to the Committee. At the request of the Committee, President Alexander had appointed Dr. Robin C. Buerki of the Graduate School of the University of Pennsylvania to serve as an adviser. Rutgers University will probably ask that the Committee on Graduate Education function as an advisory body to the University in the operation of this course.

President Alexander moved that the report and recommendations of the Committee be approved by the Board of Trustees. Seconded by Dr. Fithian, this was unanimously carried.

ELECTIONS

Chairman Norton read a communication from the Secretary of the Passaic County Medical Society recommending the appointment of Dr. Sigurd W. Johnsen of Passaic to fill Dr. McBride's unexpired term on the Board. This communication did not state whether the recommendation was an action of the Passaic County Society.

Dr. Costello moved that the communication be referred to the State Nominating Committee and that the Board take no action. Seconded by Dr. Young and carried.

Dr. Londrigan nominated Dr. Thomas B. Lee of Camden as a member of the Finance and Budget Committee from the Board of Trustees, to fill the unexpired term of Dr. Andrew F. McBride. This was seconded by President Alexander. By unanimous vote, nominations were closed and Dr. Lee was declared elected to the Finance and Budget Committee.

Dr. Londrigan moved that Dr. L. Samuel Sica of Trenton be nominated to the Finance and Budget Committee from the membership at large, to fill the unexpired term of Dr. Henry Spence. Seconded by President Alexander. By unanimous vote, nominations were closed and Dr. Sica was declared elected to the Finance and Budget Committee.

Dr. Londrigan moved that Dr. Sica be empowered to sign checks on the revolving account and authorize the payment of bills when the Chairman of the Finance and Budget Committee is not available. Seconded by Dr. Costello and unanimously carried.

It was directed that Dr. Sica be bonded in the same manner as Dr. North is now bonded.

PRESIDENT'S REPORT

President Alexander reported the following activities since the last regular meeting of the Board of Trustees:

November 1—Attended meeting with the President of the California Medical Association
November 29—Attended meeting of Postwar Economic Welfare Commission
December 3 to 6—Attended meeting of American Medical Association
December 13—Attended organization meeting of the New Jersey Cancer Society
December 14—Submitted names of six physicians to

Commissioner of Labor, Harry C. Harper, from whom he selected Dr. Henry A. Brodkin of Newark as the Medical Director of Workmen's Compensation Bureau

January 2—Attended meeting of Infantile Paralysis Foundation re March of Dimes Campaign

January 14—Attended meeting of Woman's Auxiliary to The Medical Society of New Jersey

January 24—Attended meeting with group from American Legion re veterans' problems

President Alexander stated that he had had a communication from the Paterson Evening *News* asking that the State Society take cognizance of the movement to collect funds for erection of a statue in front of the City Hall in Paterson, in memory of Dr. Andrew F. McBride. It was felt by all members present that a financial contribution should be made to this effort, and it was suggested that the entire membership be circularized and that contributions be solicited on an individual basis. Dr. Stahl moved that the Chairman appoint a committee with power to act in carrying out the above suggestion. This motion was unanimously carried and Chairman Norton appointed the following Committee:

Dr. Samuel Alexander
Dr. Alfred Stahl
Dr. E. Zeh Hawkes
Dr. Royal Schaaf
Dr. Wells P. Eagleton

It was directed that a reply be sent to the Paterson Evening *News* to the effect that the State Society endorses the movement for a memorial to Dr. McBride and that financial support will be given by individual members.

President Alexander reported that the Chairman of the Child Health Committee, Dr. Murray, would like approval of the Committee's participation in a survey of child care facilities now being conducted by the American Academy of Pediatrics. This approval was unanimously given.

AUDIT COMMITTEE

Chairman Norton read the following report from the late Dr. McBride, Chairman of the Audit Committee:

I have made a very careful examination of the report of the public accountants and auditors, and, in my opinion, they are correct and beg leave to so report.

INTER-PROFESSIONAL RELATIONSHIPS

Dr. Hollinshed, Chairman of the Committee on Inter-Professional Relationships, submitted the following report, and stated that his Committee would soon meet with representatives of the Hospital Association:

The Committee on Inter-Professional Relationships met in the office of the Society on Sunday, November 25, 1945. Those present were: Dr. Hollinshed, who presided; Dr. Scammell, Dr. Alexander and Dr. Schaaf.

It was decided that the Committee re-affirm the principles outlined in its report to the Board of Trustees under date of May 22, 1945, and that the Committee meet with a Committee representing the Hospital Association of New Jersey with the view of securing the approval and adoption of this set of principles by the New Jersey Hospital Association.

It is recommended that a joint committee of the two organizations be appointed to consider disputes and grievances arising between physicians and hospitals in their professional relationships.

VETERANS LIAISON COMMITTEE

Dr. Schaaf presented a communication from Dr. Norman M. Scott, Medical Director of Medical Service Administration, setting forth the contract between Medical Service Administration and Veterans Administration, the state-wide plan for Veterans Care and the fee schedule for care rendered veterans under provisions of the Servicemen's Readjustment Act. Dr. Schaaf asked that his Committee be empowered to negotiate a fee schedule for payment of medical care to veterans, such schedule to be subject to approval by the Trustees before adoption. This was amended to read that Dr. Scott, acting for the Liaison Committee, be authorized to negotiate a contract, including a fee schedule, with Veterans Administration and be empowered to make minor changes in the fee schedule approved by the Board of Trustees. This was unanimously carried. The plan and fee schedule were approved, but it was directed that efforts be made to raise the administrative allowance from Veterans Administration from 7 per cent to 8 per cent of the fees charged.*

Upon request from Dr. Scott for funds to put the plan into operation until payments start coming in from Veterans Administration, President Alexander moved that The Medical Society of New Jersey advance Medical Service Administration up to $5000, on a loan basis, to place the plan for medical care of veterans into operation. This was unanimously carried.

Dr. Scott reported that the Board of Governors of Medical Service Administration asks that this Board of Trustees appoint an advisory committee to Medical Service Administration, consisting of one member from each county willing to assume the responsibility for the plan within his county. Inasmuch as there already exists an advisory committee to Medi-

* The contract including our proposed fee schedule and the 8 per cent administrative charge was signed by the Veterans Administration on January 29 and is reprinted in full on page 38 of this *Journal*.

cal Service Administration in each county it was suggested that Medical Service Administration request the Chairman of each of these committees to serve as his county's representative on the Advisory Committee to Medical Service Administration.

WELFARE COMMITTEE

Chairman Norton read the report of the Welfare Committee meeting on January 13. (See below, this page.)

President Alexander moved that the report be approved, with the inclusion of veterans among the groups to be represented in the New Jersey Health Congress called for in the resolution from the Public Health Committee. With this amendment, the report was approved.

CORRESPONDENCE

1. *New Jersey Society of Clinical Pathologists*—Chairman Norton read a communication from the New Jersey Society of Clinical Pathologists requesting the State Society to set up a Committee on Laboratory Medicine. A motion to do this was unanimously carried.

2. *Venereal Disease Committee*—Chairman Norton read a communication from the Chairman of the Advisory Committee on Venereal Disease Control, Dr. Livengood, relative to an experimental case-finding project proposed by the Department of Health. The Department of Health advocates penicillin in the treatment of syphilis and proposes to have all cases found referred to hospitals for eight days of penicillin treatment. The Committee approves the case-finding project, but is opposed to having the Board of Health predetermine individual treatment and hospitalization. On motion the case-finding project was approved. Dr. Costello moved that we disapprove the proposal for hospitalized penicillin treatment of venereal disease cases found, as suggested by the Department of Health. Seconded by Dr. Londrigan and unanimously carried.

RESOLUTIONS RE DEATH OF DR. McBRIDE

Chairman Norton appointed the following committee to draw up resolutions on the death of Dr. Andrew F. McBride, to appear on the minutes of the Board of Trustees and to be sent to the family of Dr. McBride:

Dr. Samuel Alexander
Dr. Alfred Stahl
Dr. Wells P. Eagleton

CAMDEN COMMUNITY HEALTH SERVICE

Dr. Scott read a report, prepared by Mr. Sorg, counsel to Medical-Surgical Plan, in connection with the suit brought by Community Health Service of Camden to have the Enabling Act under which Medical-Surgical Plan operates declared unconstitutional or, in any case, not applicable to them. Any hearing will be postponed until the Community Health Service of Camden can ascertain the attitude of the Camden County Medical Society toward their program. A copy of Mr. Sorg's communication is on file in the Executive Offices.

Dr. Londrigan moved that Mr. Sorg's communication be sent to the Camden County Medical Society, as a privileged communication. Seconded by Dr. Coleman and unanimously carried.

Upon motion the meeting was adjourned at 4:55 p. m.

EDITH L. MADDEN,
Acting Executive Officer.

WELFARE MEETING

A meeting of the Welfare Committee was held at the Headquarters of the State Society, Trenton, on Sunday, January 13, 1946. Dr. Sigurd W. Johnsen, Chairman, presided.

ATTENDANCE

Sigurd W. Johnsen, Chairman
Herschel S. Murphy, Vice-Chairman
Samuel Alexander, President
Alfred Stahl, Secretary

Atlantic—David B. Allman
Bergen—William K. Harryman
Camden—H. Wesley Jack
Essex—Harrold A. Murray, J. Wallace Hurff
Gloucester—Wendell J. Burkett, Chester I. Ulmer
Hudson—Reeve L. Ballinger, B. S. Pollak, J. Lawrence Evans
Mercer—Walter E. D'Arcy, L. Samuel Sica
Middlesex—William C. Wilentz, Ralph J. Faulkingham
Monmouth—Thomas H. Andrews, Stanley Nichols
Ocean—William E. Dodd
Salem—Harry F. Suter
Sussex—Martin I. Kirschner
Union—Thomas J. Walsh
Consultants—Frederic J. Quigley, Emil Frankel, William H. MacDonald, John J. Debus

Guests—Col. J. C. Harding, Thomas K. Lewis, A. W. Ruoff, Baxter A. Livengood, Oram R. Kline, Edwin R. Ristine, L. S. Snegireff, Arthur Hasking, Royal A. Schaaf, Rudolph Schretzmann, Mr. H. A. Borchert, Harry Wolfson, Wayne W. Hall, William O. Cary, Edward Z. Hawkes, W. G. Herrman, Granville L. Jones, C. B. Blaisdell, J. O. Hill, Joseph F. Londrigan, William L. Rumsey, John H. Rowland, George A. Fithian, Watson B. Morris, R. M. Grier, Edward Guion, T. R. Robie, A. Charles Zehnder, George Blackburne, C. A. Plume, William H. Costello, Walter B. Mount, C. H. Rothfuss, Abraham E. Jaffin, Mrs. William E. Dodd, Mrs. F. A. Hayes, Evelyn T. Walker, F. E. Elliott (New York), Norman M. Scott, Henry A. Davidson, Editor.

Chairman Johnsen opened the meeting at 2:00 p. m., and called on President Alexander, who reported on the meeting of the A. M. A. House of Delegates in Chciago in December. He was impressed with the seriousness of the discussion at that meeting. Some of the important subjects were: (1) Medical-Surgical Plans. It was the general sense of the group there that a plan should be set up in every state, so that when the question of medical care comes up in discussion we can say we have a way of taking care of the public. This was approved by the House of Delegates. (2) Care of returning veterans. The Delegates realized this was a challenge to Organized Medicine and that we had to solve it. A most stimulating talk was made by General Hawley, and all were impressed with his willingness to coöperate with Organized Medicine. (3) Much time was devoted to the Wagner-Murray-Dingell Bill.

Dr. Alexander urged the selection of an Executive Officer by the State Society. Excessive work has been thrown on the office staff, which has coöperated splendidly, but the President saw an urgent need for an Executive Officer.

Dr. Norman M. Scott reported on the Medical-Surgical Plan. As of November 30, 1945, we had an enrollment of 49,775, as compared to 30,200 on January 1, 1945. For the 11 months of the year our experience was as follows:

Earned Subscription Income—$294,000, as compared to $166,000 last year.

Claims Paid—$195,000, 66.4 per cent of our earned income, as compared to $117,000, 70 per cent of our earned income, last year.

Operating Cost—$51,000, 17½ per cent of earned income, as compared to $31,000, 18.7 per cent of earned income, last year.

Our reserves for the 11 months total $47,000, or 16 per cent, as compared to $18,000, or 10 per cent, last year.

Hospital admission rate was 84 per 1,000, as compared to 89 per 1,000 last year.

In some respects our Plan is the most successful Plan in the country. It has never been in financial difficulty; it has paid all of its expenses and all claims from earned income; and has set aside satisfactory reserves. It is the only state-wide plan providing medical-surgical benefits under its basic contract. Over 3500 participating physicians have given loyal service. Our new contract, providing full payment on an income limit basis, has proved even more satisfactory than the old contract.

Medical Service Administration continues to operate Farm Security Medical Plan. The condition of Farm Security Plan has improved and it is better than it was last year despite a decrease in the size of its enrollment due to increased income of the farm groups. The Plan has paid its full fee schedule.

The City of Newark Plan continues to be a successful demonstration of the care of the medically indigent. The only change in the past year has been the decrease in the number of indigent and the increase in the number of medically indigent, which is now about twice that of the indigent load.

Medical Service Administration is attempting to solve the problem of medical care for veterans. The first edition of a plan has been submitted to the Veterans Administration, and has been approved by the Regional Office.* Community hospitals and the medical profession have been slow in appreciating the importance and magnitude of this problem. *It is the most important problem we have ever tackled.* More than 142,000 men in New Jersey are now awaiting examinations for pension benefits. First need of the Veterans Administration is to have examination centers. Much personnel will be needed in each center to do the work.

The House of Delegates of the A. M. A. instructed the Trustees to proceed rapidly with the development of a national health program, with emphasis on nation-wide organization of prepayment medical plans sponsored by medical societies. A committee, appointed as advisory to the Council on Medical Services and Public Relations, has held two meetings, and has filed a report with the Trustees of the A. M. A. recommending a non-profit organization to be known as National Voluntary Health Association with a capital of $500,000, to be operated under the direction of the Board of Trustees of the A. M. A. and the Council on Medical Services and Public Relations. This organization would act as a holding company and would organize a national prepayment plan.

* For details of plan see page 38 of this *Journal*.

Chairman Johnsen read a letter from General Hawley expressing regret that he would be unable to attend the meeting and introduced Colonel J. C. Harding, General Hawley's representative, who addressed the meeting.

Dr. Schaaf: First meeting of the Veterans Liaison Committee was on November 25, at which time the committee met with the A.M.A. Delegates. They formulated principles which were introduced by our Delegates at the meeting in Chicago in December and which were adopted by the A. M. A. The committee recommended that the Monmouth County Plan be adopted in toto as modified by certain recommendations presented by Essex County. The committee then approved the plan of the Medical Service Administration for managing the financial details. I move that the first portion of this report be approved. (Seconded by Dr. Ulmer and unanimously carried.)

The adoption of a fee schedule has been a controversial question for a good many years. Recognizing that, your committee submits the following recommendation:

Although we disapprove in principle the establishment of fixed schedules controlling the fees for any type of group medical care, we realize the absolute necessity of some coördinated plan for the payment of medical services to veterans; and we therefore recommend that an agreement for the payment for such services be negotiated with the Veterans Administration—said agreement to be state-wide in application, the fees to be in line with those prevailing in the more populous areas for the care of persons included in the middle income group who usually engage in semi-private hospital accommodations.

The committee moves that this be adopted. (Seconded and unanimously carried.)

REPORTS OF SUB-COMMITTEES

Legislation

Dr. Pollak moved the adoption of his report (see page 59). (Seconded and unanimously carried.)

Medical Practice

In the absence of both the chairman and vice-chairman, Chairman Johnsen presented the actions taken by the Medical Practice Committee.

1. The committee approved the Medical Care Plan for Veterans as presented by Dr. Scott.

2. The committee approved the establishment of nutrition deficiency clinics in various sections of the State under auspices of the Medical Society, as requested by the State Department of Health.

(Upon motion the report of the Medical Practice Committee was unanimously approved.)

Public Health

Dr. Stanley Nichols reported progress for the Cancer Control program. He also announced that Alcoholic Beverage Commissioner Driscoll feels that something should be done by the state about the alcohol problem. He has asked Rutgers University for a study of alcoholism. Professor Riley of Rutgers met with the committee and asked the Medical Society to assist Rutgers in the study. This matter has been referred to our Mental Hygiene Advisory Committee with the request that the University be given whatever assistance possible.

The Mental Hygiene Committee has recommended:

That the State Society recommend that the request from the State Department of Institutions and Agencies for funds for additional accommodations and enlargement of facilities of the institutions for the insane, epileptic and feeble-minded be granted by the Legislature.

(Dr. Nichols moved that this recommendation be adopted. Seconded by Dr. Guion. Upon motion it was amended to the effect that a copy be sent to the Governor, Speaker of the House and President of the Senate. Motion was unanimously carried.)

Dr. Nichols then introduced the following resolution:

Whereas, The House of Delegates of the American Medical Association has recently directed the Council on Medical Services and Public Relations to create a National Health Congress of official representatives of the health professions and agencies and organizations interested in the betterment of public health and medical care and has strongly urged the immediate creation of State and Community Health Conferences or Councils of similar composition, and

Whereas, The year 1946 is to be the year of decision in these United States as to whether *voluntary* coöperative methods or *compulsory* bureaucratic methods shall be used to accomplish these ends, therefore

Be It Resolved, That the Welfare Committee of The Medical Society of New Jersey comply with the request of the American Medical Association and direct the Public Relations Committee, with the assistance of the Legislative, Public Health, and Medical Practice Committees, to take immediate steps to create a voluntary New Jersey Health Conference of official representatives of the five health professions, the State Legislature (and State agencies interested in health), Industry, Labor, and Agriculture, for the purpose of considering and promoting jointly all matters which affect the public health and medical care of the citizens of this State.

(Upon motion by Dr. Nichols, regularly seconded, this resolution was unanimously passed.)

Public Relations

Dr. L. Samuel Sica reminded the Society that the objective of his committee is to evolve a program of public relations which will secure and retain the good will of the people of New Jersey toward Organized Medicine in general and toward The Medical Society of New Jersey in particular.

The program we are evolving is presented to the public from the standpoint of promoting and protecting the welfare of the people as a whole. It is educational in nature, to inform our people how they may best guard their health and to inform the public regarding the profession's opinion on current medical and medico-economic problems.

The avenues of approach used have consisted of the radio, the press and public speakers.

The radio program consists of four fifteen-minute broadcasts a week. The broadcast material is in the form of electrical transcriptions received in record form from the American Medical Association. The present series of broadcasts is called "Before the Doctor Comes", advising the public on the medical care to be rendered during the more common illnesses and medical emergencies. There is no charge to the Society for the material used and the following stations donate the radio time:

Newark	Station WAAT	Sunday, 10 a. m.
Trenton	Station WTTM	Friday, 1 p. m.
Paterson	Station WPAT	Sunday, 10 a. m.
Atlantic City	Station WFPG	Sunday, 4 p. m.

Through the facilities of the New Jersey Press Association we are issuing 300 releases a week to the daily and weekly newspapers. Similar releases are issued through the offices of the Society to 75 industrial house organs. These are titled "Health Hints", and consist of articles of about 300 words on common medical subjects written in a style to attract the attention of lay readers. Each newspaper is furnished with this release in the form of a printer's proof and a printer's mat. The cost of these releases is about $100 a week. We do not have a clipping service to determine how many newspapers are using these releases. After a trial period each newspaper in the state will be asked for this information. The use of these releases could be increased through the active influence of county societies with local papers.

A representative of the committee has appeared before 25 lay groups during the fall and winter season to speak upon matters relating to current legislation and methods proposed by the medical profession to meet the demand for improvement in medical care distribution. The public is more interested in any program proposed by the profession than in a federal program. This is true except among certain labor groups which have a fixed opinion in favor of compulsory health insurance. These groups are not impressed with any argument against compulsory health insurance. The only approach which has any effect on their thinking is on the basis of the principles of democracy. The number of requests for public speakers on these subjects is less than last year, indicating that the opinions of the various groups is becoming crystallized. We believe the tendency at present is more in favor of the philosophy of the medical profession than the philosophy behind compulsory health insurance.

With the increased amount of work placed on Dr. Scott, who has been acting as Executive Secretary to the committee for the past five months, the committee relieved Dr. Scott of this added burden of work and recommends that Dr. Henry A. Davidson be appointed Executive Secretary of the Public Relations Committee at a salary of $100 a month, effective January 1, 1946.

Dr. Sica asked for some reaction from the membership throughout the state on what they might hear from their patients on the articles they see in local newspapers or what they hear over the radio. The committee will be grateful for any comments on these two projects.

(Upon motion by Dr. Sica, seconded by Dr. Pollak, the report of the Public Relations Committee was unanimously adopted.)

Advisory Committee on Tuberculosis and Adult Disease Control

Chairman Johnsen asked permission to reopen the Public Health Committee report. Dr. Jaffin, Chairman, submitted the following:

The Advisory Committee on Tuberculosis and Adult Disease Control feels that for the time being recommendations on tuberculosis can be set aside so that we may devote some attention to adult disease control.

First of these deals with chest surgery. The committee recommends that a survey of chest surgery in New Jersey be made to determine the number of chest surgeons in New Jersey, hospitals doing chest surgery and possibilities for training in New Jersey of chest surgeons.

The committee recommends further that in view of the number of vacancies in tuberculosis hospitals, advantage be taken of these empty

beds so that cases of non-tuberculous major thoracic surgery can be taken care of in New Jersey and not sent to neighboring states.

In reference to penicillin the committee recommends that the Journal, the Board of Health and the Public Relations Committee inform the profession of the scarcity of the drug and urge it to be used wisely and only where indicated.

We also recommended to the Pharmaceutical Problems Committee that a fact finding investigation be made of the remedies recommended by the manufacturers and distributors of patent medicines for the common cold.

In reference to chronic asthma it was felt there was a great need for attention to this problem in clinics and that there are not enough places where those suffering can go for treatment. There is a need for education and facilities for diagnosis as well as treatment.

(Upon motion, regularly seconded, the above was added to the report of the Public Health Committee and unanimously adopted.)

Upon motion, regularly seconded, the meeting was adjourned at 3:50 p. m.

EDITH L. MADDEN,
Acting Executive Officer.

REPORT OF SUB-COMMITTEE ON LEGISLATION

January 13, 1946

Four years ago the activities of this Committee were concerned almost exclusively with state legislation. For the past two years our major efforts are, of necessity, directed to federal legislation. This we have attempted to do without slighting in any way the important state legislative activities which continue to demand considerable time and effort.

FEDERAL LEGISLATION

While the decision of the House of Delegates of the American Medical Association to extend as rapidly as possible to all states voluntary medical indemnity plans is to be applauded, it is to be regretted that this was not coupled with a greater recognition of the need for government subsidies for the care of the medically indigent.

It is our belief that (1) adequate medical care plans and hospitalization insurance, (2) recognition by government of its responsibility for care of the medically indigent and sound coöperative plans to meet this need between government and the medical profession, and (3) increased hospitalization throughout the country as proposed by Senate Bill 191 would be sufficient to meet, on an evolutionary basis, the present need for improved distribution of medical care.

It is expected that hearings before subcommittees of the Committee on Education and Labor of the Senate will be held on the Pepper Bill (S. 1318)—maternal and child welfare—and S. 1606, the latest Wagner-Murray Bill, which contains the provision for compulsory sickness insurance. While of course our Society's contribution of efforts to defeat these measures must be coördinated with the plans of the A. M. A., nevertheless, we are strongly of the opinion that our Society should be adequately represented at hearings on both of these bills. In state legislative work we know that the legislators are influenced by representations made by the State Society on important and controversial measures; our experience teaches us that the greatest effect on our state legislators stems from the representations made by County Society Keymen. Our national legislators will give careful consideration to the representations made by the American Medical Association relative to these bills—the Pepper Bill and the Wagner-Murray Bill—but what the Senators of New Jersey, as well as the Senators of each of the other states, will wish especially to know is what the doctors of their own state think of these measures. A delegation from our own Society, at hearings on both of these bills, competent to express the opinion of Organized Medicine of this state, will impress our Senators far more than will the representations of the A. M. A. alone. It is particularly important for New Jersey to be represented at these hearings because one of our Senators—Senator H. Alexander Smith—is a member of the Committee on Education and Labor, which will conduct the hearings on both these bills.

STATE LEGISLATION

It may be recalled that in our report to the Welfare Committee at its last meeting, in October, we mentioned that the chiropodists asked to have some representation on the Board of Medical Examiners. In November President Alexander, Chairman of the Legislative Committee, Dr. Pollak, and the Executive Secretary, met with three representatives of the New Jersey Chiropodists Society and discussed this matter. It is recommended that the Board

of Medical Examiners continue to be composed of *eleven full* members and a "qualified" member who shall be a chiropodist, and that 45:9-1 of the Medical Practice Act be amended to accomplish this purpose. We recommend the following with respect to the chiropody member. The language of this proposal has been approved by counsel to the Society.

The chiropody member shall have equal rights and privileges in all matters affecting chiropody, but shall vote only on chiropody matters and shall have no vote on the selection of officers.

Inasmuch as this suggested amendment to the Medical Practice Act is of importance it is recommended that, if endorsed by the Welfare Committee, the Board of Trustees be advised of this action and their approval requested.

A joint meeting of this Committee and the Sub-Committee on Public Health was held this morning to discuss the provision of A-404—to reorganize the State Department of Health—which was introduced for study *only* April 9, 1945, and which, we understand, will be reintroduced for action at this session of the Legislature. As a result of this joint meeting, and in the absence of any knowledge as to what the new bill may contain, no action was taken. If and when a new bill is introduced copies will be sent to members of the Welfare Committee for their opinion.

WITH NEW JERSEY MEDICAL AUTHORS

Compiled by Mildred V. Naylor, Librarian, Academy of Medicine

It is requested that any New Jersey physician who publishes an article outside the state, notify the Editorial Office in Trenton, giving the title of the paper and the name of the periodical, as well as the month, date, volume and page number. It would also be helpful to this office if members would notify us of articles published by their colleagues.

Ben-Asher, S.—Jersey City
Treatment of anginal syndrome with thiouracil. J. Med. Soc. New Jersey 42: 401-406, Dec. '45

DuBois, A. S.—see Valko, E. I.

Eichler, Bernard B.—Montclair
Aneurysm of aorta with compression of pulmonary artery and left ventricle. Ann. Int. Med. 23: 652, Oct. '45

Halprin, Harry, and Murray W. Shulman—Newark (in service)
Acute cor pulmonale. J. Med. Soc. New Jersey 42: 353-357, Nov. '45

de Hellebranth, R. T.—Ventnor
Reducing the period of post-operative bed rest. J. Med. Soc. New Jersey 42: 399-400, Dec. '45

Jaeckle, Charles E.—South Orange (in service) (with A. Schultz)
Plastic surgical repair about the eyes with free grafts. Arch. Ophthal. 34: 103, Aug. '45

Orton, Henry B.—Newark
One of the co-authors of Jackson, C., and Jackson, C. L., ed.
Diseases of the Nose, Throat and Ear. Saunders. 1945

Potter, Ellen C.—Trenton
The year of decision for social workers. Soc. Serv. Rev. 19: 297, Sep. '45
Health and welfare services. Ann. Am. Acad. Political & Soc. Sciences 242: 139, Nov. '45

Quackenbos, H. M.—Trenton
Archetype postures; clinical impressions. Psychiat. Quart. 19: 1-3, Oct. '45

Shivers, Charles H. deT.—Atlantic City
Bilateral orchiectomy in advanced or recurring carcinoma of the bladder with severe subjective symptoms. A preliminary report. J. Urol. 54: 539-546, Dec. '45

Shulman, Murray W.—see Halprin, Harry

Singer, Paul; Joseph J. Sottilaro and Hermann Vollmer—Jersey City
Comparison of the tuberculin patch test and the collodion-tuberculin test. Am. Rev. Tuberc. 52: 521-525, Dec. '45

Sottilaro, Joseph J.—see Singer, Paul

Valko, E. I., and A. S. DuBois—Jersey City (Onyx Oil & Chemical Co.)
Correlation between antibacterial power and chemical structure of higher alkyl ammonium ions. J. Bact. 50: 481-490, Oct. '45

Vollmer, Hermann—see Singer, Paul

Warter, Peter J.—Trenton (with others)
Streptococcus-staphylococcus combined antigens in treatment of rheumatoid arthritis. (Streptococcus toxin—Bacterial suspension) with (Staphylococcus toxoid—Bacterial suspension). J. Med. Soc. New Jersey 42: 391-398, Dec. '45

YOUR MEDICAL MENU FOR MAY

Advance Announcement of the 180th Annual Meeting

THE MEDICAL SOCIETY OF NEW JERSEY

The first postwar Annual Meeting promises to be professionally stimulating, socially companionable, and administratively productive. While program details are still incomplete in a few spots, here's the score to date:

The Place—Claridge Hotel, Atlantic City.
The Days—Tuesday, Wednesday, Thursday, May 21, 22 and 23.

The Time—Tuesday	11:00	A. M.—House of Delegates.
	2:00	P. M.—General Session.
Wednesday	9:30	A. M.—Scientific Programs (Sections).
	12:30	P. M.—Election, House of Delegates.
	2:00	P. M.—Scientific Programs (Sections).
	5:00	P. M.—Social Session
	7:30	P. M.—Banquet.
Thursday	10:00	A. M.—General Session.
	1:30	P. M.—House of Delegates.

SCIENTIFIC PROGRAMS

Wednesday Morning: Medicine, Radiology, Obstetrics, and Eye, Ear, Nose and Throat
Wednesday Afternoon: Surgery, Pediatrics, and Gastro-Enterology and Proctology

MEDICINE

Talks on: (a) emotional problems of the veteran, and (b) reducing cardiac mortality.

RADIOLOGY

Illustrated presentation of the problem of congenital obstructions in the newborn.

OBSTETRICS AND GYNECOLOGY

(a) Management of premature labor. (b) Reduction of maternal mortality. (c) Protection of newborn infants. (d) Obstetrical anesthesia and analgesia.

EYE, EAR, NOSE, THROAT

Papers on (a) Aural rehabilitation and (b) War casualties in an Army eye center.

SURGERY

Papers on: (a) Carcinoma of the rectum, (b) Thrombophlebitis and pulmonary embolism and (c) Surgical treatment of hypertension.

PEDIATRICS

Session will be devoted to a panel-discussion on rheumatic fever with special presentations on heart disease, the school health program, and state and community projects for the control of rheumatic fever.

GASTRO-ENTEROLOGY AND PROCTOLOGY

Papers on (a) intestinal parasitism, (b) neoplasm of the colon, (c) common ano-rectal conditions and (d) ulcer therapy.

Further details in subsequent issues of the Journal.

SECTION OFFICERS

CHAIRMAN		SECRETARY
J. F. PESSEL, M.D.	*Medicine*	A. J. V. KLEIN, M.D.
H. J. PERLBERG, M.D.	*Radiology*	H. R. BRINDLE, M.D.
H. C. CURTIS, M.D.	*Obstetrics and Gynecology*	A. B. DAVIS, M.D.
G. P. MEYER, M.D.	*Eye, Ear, Nose and Throat*	J. P. BRENNAN, M.D.
J. C. COX, M.D.	*Surgery*	F. M. CLARKE, M.D.
S. BLAUGRUND, M.D.	*Pediatrics*	L. C. V. DUBUSC, M.D.
S. B. KAPLAN, M.D.	*Gastro-Enterology and Proctology*	L. C. PERKEL, M.D.

PRELIMINARY LIST OF SPEAKERS

MEDICINE

Joseph C. Yaskin, M.D.
William D. Stroud, M.D.

RADIOLOGY

John Caffey, M.D.

OBSTETRICS

John C. Hirst, M.D.
Charles A. Weymuller, M.D.
Robert MacKenzie, M.D.
James F. Norton, M.D.

EYE, EAR, NOSE & THROAT

Frederick Herbert, Captain, M.C., U.S.N.
Elliott Randolph, Lt. Col., M.C., U.S.A.

SURGERY

Damon B. Pfeiffer, M.D.
Robert R. Linton, M.D.
Reginald Smithwick, M.D.

PEDIATRICS

William D. Troud, M.D.
George M. Wheatley, M.D.
J. G. Fred Hiss, M.D.
Betty Huse, M.D.

GASTRO-ENTEROLOGY AND PROCTOLOGY

Manfred Kraemer, M.D.
Louis C. Perkel, M.D.
Co Tui, M.D.
H. Mathesheimer, M.D.

Complete list of speakers will be published in subsequent issues of the Journal and in program released at the meeting.

EXHIBITS

Every booth has been taken and our exhibitors have an unusual program of educational and commercial exhibits. With many of the war restrictions lifted, these displays will be exceptionally eye-catching, instructive and interesting.

WOMAN'S AUXILIARY

Because of limitations of space, the 19th Annual Meeting of the Woman's Auxiliary will be held at the Brighton Hotel, across the street from the Claridge. Chief events will be on Wednesday, May 22. The complete schedule follows:

TUESDAY, MAY 21

10:00 A. M.—Registration and Reservations.
1:00 P. M.—Executive Board.
4:00 P. M.—Rolling Chair Ride.
7:30 P. M.—Fellowettes Dinner.

WEDNESDAY, MAY 22

9:30 A. M.—Business Session.
1:00 P. M.—Luncheon.
3:00 P. M.—Business Session.
5:00 P. M.—Social Session (at the Claridge).
7:30 P. M.—Banquet (at the Claridge).

The new Executive Board will meet Thursday at 10:30 A. M.

NEW GOVERNMENT CAREERS FOR M.D.'s

On January 4, 1946, President Truman signed a law establishing a Department of Medicine in the Veterans Administration. This sets up the most attractive career yet offered to physicians in Federal Government Service. Pay scales are relatively higher than salaries paid in similar grades in other branches of the public service. Specialists who hold the diploma of the American Boards get a 25 per cent increment in pay, so that qualified consultants interested in devoting full time to the Veterans Administration may be paid up to $11,000 a year. General practitioners and young men interested in qualifying as specialists are afforded residencies acceptable to the American Boards.

The new arrangement indicates that promotions will be made on recommendation of special selection boards and that these promotions will be based primarily on merit and demonstrated efficiency. The Service offers a wide variety of grades commensurate with the experience and skill of the doctors at pay ranging from $3,640 to $11,000. This is *not* commissioned service and no Medical Corps has been set up in the Veterans Administration. The arrangement is a free one and doctors are at liberty to leave the Service at any time, although it is hoped that most of the physicians will be interested in making this their career. Although not under Civil Service, physicians in the new Veterans Administration will receive all the benefits of the Civil Service Retirement Act. For further details write to the Chief Medical Director, Veterans Administration, Washington 25, D. C.

OBITUARIES

ANDREW FRANCIS McBRIDE, M.D., K.S.G.

(Also see editorial, page 35.)

Andrew F. McBride, citizen, physician, soldier, banker and public servant, died January 3, 1946, closing an unequaled career of varied achievement. With all the honors and titles that came to him he always preferred to be known simply as "Doctor McBride". He has been memorialized and honored as a great civic leader, as the Mayor of Paterson, as State Labor Commissioner, as the President of one of our largest financial institutions, and by his Church as Knight of St. Gregory. None of these interests ever diverted his attention or lessened his interest in medicine. To the very end he continued to practice his chosen profession. To his patients he was a hope and consolation, to his fellow members in the profession a wise counsellor and a faithful friend. He drove himself hard. His relaxation was work. He gave early evidence of his ability both as an organizer and executive. He had a great heart and a remarkable gift for making and keeping friends. His activities brought him in contact with all sorts and conditions of men so that he had a close view of both the noble and the ignoble motives that control human conduct. He was ruggedly honest. He fought passionately for his beliefs and brooked no interference with a course of conduct that was right. He was courageous and impatient with sham, pretense and glamour. Tolerant towards other's point of view, sympathetic and kind to those who had fallen by the wayside, he made every effort to see that they were restored as useful members of society.

Medical honors came rapidly in his long career. Member of the Board of Health, County Physician, Fellow of the American College of Surgeons, member of the State Surgical Society, president of the Passaic County Medical Society, President of the State Medical Society, member of the Board of Trustees and Delegate to the A. M. A. His most notable work was done as a member of the Welfare Committee of the State Society. Every important constructive piece of medical legislation in the past decade bears the imprint of his influence.

His career at St. Joseph's Hospital began as an intern in 1890, a year after his graduation from Columbia University. Later he became Associate and then Attending Surgeon and member of the Board of Governors of that hospital. For two years he was president of the Medical Staff.

We will miss Dr. McBride in the profession but he has left us the memory and example of a great man, admired and respected not only for his professional attainments but for his intellectual honesty and personal integrity.

DR. CASPER H. CLAUS

Dr. Casper H. Claus, a surgeon and radiologist of Newark, died at St. Vincent's Hospital, Montclair, on November 30, 1945, at the age of 54.

Dr. Claus was graduated in 1919 from Georg August-Universität Medizinische Fakultät, Göttingen, Prussia, and came to the United States in 1932.

DR. HARVEY S. BROWN

Middlesex County lost one of its oldest and best known practitioners on December 17, 1945, when Dr. Harvey S. Brown died in the Philadelphia Naval Hospital at the age of 70. Graduated from the University of Maryland in 1899, Dr. Brown established himself in Freehold in that year and has been closely identified with Middlesex County's medical affairs ever since. He served in World War I, first as a captain, later as a major, in the Medical Corps. He was for 13 years an active member of Freehold's Board of Health and served as Health Officer of that county seat from 1920 to 1943. In 1923, Dr. Brown was elected President of the N. J. Health Officers Association.

DR. FRANCIS E. McCONAUGHY

Dr. Francis E. McConaughy, who retired in 1944 after 54 years of private practice, died in Ridgewood on January 13. Dr. McConaughy, a graduate of Flower Hospital, practiced in Somerville until 1896, when he moved to Ridgewood.

He was past-president of the Somerset County Medical Society and is noted throughout the state for his interest in welfare activities. He was one of the organizers of the Somerville Y. M. C. A. His particular field of interest was always the welfare of the Negro people, and he was said to have been instrumental in affecting the admission of Paul Robeson to Rutgers University. In 1941 Dr. McConaughy was honored by the Somerset County Medical Society for having had more than a half century of practice in that county.

DR. ORRIS W. SAUNDERS

Dr. Orris W. Saunders, Camden practitioner since the turn of the century, and a civic leader in the Eighth Ward, died in Camden on January 13. He has served as city councilman, as coroner, county physician and a member of the Board of Managers of the Camden County Tuberculosis Hospital. He was graduated from the Jefferson Medical College in 1888. Dr. Saunders was one of the organizers of the Parkside Trust Company and was active in banking, medical and civic club affairs for many years.

DR. WILLIAM SPICKERS

Dr. William Spickers, 62, director of surgical services at Barnert Memorial Hospital, Paterson, died on December 28, 1945, following a heart attack at his home in Franklin Lakes, N. J.

Born in Paterson, Dr. Spickers was graduated from Columbia University's College of Physicians and Surgeons in 1936. He was originally a radiographer at the Paterson General Hospital and later became an assistant in surgery there. Always active in medical affairs, Dr. Spickers was at one time president of the Passaic County Medical Society.

THE BULLETIN BOARD

The cleverly written, interesting leaflet *Please Keep Me Safe,* which points up home accident hazards to children, is now available for free distribution to M.D.'s. Placing a supply of these on your waiting room table is a real service to the mothers and babies of your community. For your package of leaflets, write to Woman's Division, Newark Safety Council, 24 Branford Place, Newark 2, New Jersey.

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Fellowships in Anesthesiology are available to applicants who file before July 1, 1946, with the Division of Medical Sciences, National Research Council, 2101 Constitution Avenue, Washington 25, D. C. Fellowship stipends vary from $2,000 to $3,000 a year.

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The National Gastroenterological Association offers a prize award of $100 for the best previously unpublished contribution on gastroenterology. The competition is open only to members of the A. M. A. (which includes all members of The Medical Society of New Jersey). The manuscript is limited to 5,000 words, submitted in five copies to the National Gastroenterological Association, 1819 Broadway, New York 23, N. Y., before May 1, 1946.

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Physicians are invited to participate in a conference to discuss revision of United States Pharmacopeia Standards. The conference begins Friday morning, February 15, at 10 a. m. in the Hotel Pennsylvania, New York, and the suggestion of any practicing M. D. will be received by the conference.

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The American College of Surgeons announces a series of sectional meetings at which modern problems in surgery will be discussed or presented. These meetings will be held in Pittsburgh on March 11 and 12; Boston, March 18 and 19; Montreal, March 22 and 23; and Detroit, March 26 and 27. Interested surgeons may obtain details by writing to the American College of Surgeons at 40 East Erie Street, Chicago.

• • •

"Rheumatic Fever" will be the topic of the next meeting of the Passaic County Medical Society at 9 p. m., Tuesday, February 19, in the Freeholders' Room of the County Administration Building, Paterson, N. J.

Otologists and ophthalmologists are reminded that an annual two-day meeting of the Pennsylvania Academy of Ophthalmology and Otolaryngology is to be held Wednesday and Thursday, April 24 and 25, at Marion, just outside of Philadelphia. For further details write to Dr. Paul C. Craig, 232 N. 5th St., Reading, Pa.

• • •

The annual prize contest of the American Association of Obstetricians, Gynecologists and Surgeons will be conducted again this year. For information write to Dr. James R. Bloss, 418 11th St., Huntington, W. Va.

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A talk on blood transfusion and the Rh factor will be given by Dr. Eugene M. Katzin to the Somerset County Medical Society meeting at 9:00 p. m., Thursday, February 14, at the Somerset Hospital.

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A new publication to be known as the Quarterly Review of Pediatrics appears this month under the editorship of Dr. Irving J. Wolman. This periodical promises to make available for the busy practitioner abstracts of recent progress in all branches of pediatrics. Subscriptions and contributions should be sent to Dr. Wolman at the Children's Hospital, 1740 Bainbridge Street, Philadelphia 46, Pa.

• • •

A lecture on disorders of the spleen will be delivered Friday afternoon, March 1, at 4:30 at the New York Academy of Medicine (2 East 103rd St.) by Dr. Robert H. Elliott of Columbia University. Indications for surgical treatment of gastric ulcer will be discussed by Dr. J. W. Hinton at the same place on Friday, March 8, at 4:30 p. m.

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Physicians interested in hyperthyroidism are invited to participate in the meeting of the Middlesex County Medical Society, to be held Wednesday, February 20, 9:00 p. m. in the Roosevelt Hospital at Metuchen, N. J. The speaker, Dr. Martin G. Vorhaus, will discuss thiouracil in the treatment of hyperthyroidism.

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Recipients of the 1946 Lasker Foundation awards for the most significant contribution to research in human fertility are Robert Latou Dickinson, M.D., of New York and Irl G. Riggin, M.D., of Richmond, Va.

COUNTY SOCIETY REPORTS

ATLANTIC COUNTY

Walter B. Stewart, M.D., Reporter

Regular monthly meeting of the *Medical Society of Atlantic County* was held at the Hotel Chelsea on January 11. A dinner was given in honor of the speaker of the evening, WILLIAM HARVEY PERKINS, M.D., Dean and Professor of Preventive Medicine, Jefferson Medical College. DR. EDWARD GUION, President of the County Society, introduced Dr. Perkins, who chose as his subject: *"The Doctor Is the Public Too!"* Dr. Perkins gave a challenging talk on the civic and social responsibilities of the physician. In the eyes of the public, the physician seems no longer to be the outstanding "family doctor" of fifty years ago. To restore his prestige, he should participate more actively in community health activities, social welfare and the education of the public, thus helping to combat current trends toward socialization of medicine. We are also citizens and the public too.

DR. DAVID B. ALLMAN thanked the speaker, and then introduced DR. R. C. FAGLEY, Chief Medical Officer of the Veterans Administration for New Jersey. Dr. Fagley said that main purpose of his visit was to learn what plans Atlantic County was making for the care of returning veterans. He described programs endorsed by several other counties, and presented a plan sponsored by the Veterans Bureau at Lyons. Dr. Allman, Chairman of the Post-War Planning Committee, hopes soon to have an Atlantic County plan, designed for our local conditions and of local origin, which can be presented to the society. Service-connected disabilities will be treated locally under the program of the Veterans Administration, so far as possible, on the basis of fixed uniform fees for medical and surgical service and hospitalization, through coöperation with local doctors and hospitals. The presentation was discussed from all angles and at considerable length.

DR. ROBERT BRADLEY, reporting for the Board of Censors, approved the application for regular membership of DR. CHARLES SASEEN, and for associate membership of DRS. CHARLES MORROW, LOUIS REINHART *and* HARRY DEIN. The Society voted their election. The County Society, after hearing a description of the Ragweed Control Program by Dr. Charles Hyman, went on record as endorsing it.

BURLINGTON COUNTY

T. B. Dickson, M.D., Reporter

Regular meeting of the *Burlington County Medical Society* was held at the Burlington County Hospital on January 10, 1946.

DR. THOMAS J. SUMMEY, the President, welcomed back Drs. Dean LeFavor, Joseph Kudor and Edward Wyman, all of whom had just been separated from the armed forces.

At the suggestion of Dr. Summey, DRS. JOSEPH STOKES, SR., and NATHAN THORN were made honorary members of the County Society.

Guest speaker was DR. PERRY MACNEAL, Chief of the Medical Service of the Burlington County Hospital, who spoke on the migraine syndrome. Dr. MacNeal described migraine as periodic headaches occurring in people of good health. He also spoke of abdominal migraine or cyclic vomiting which occurs in children. Causes of migraine are many, the two most common being familial and allergic. More women are afflicted with it than men in a ratio of 3 to 1. Dr. MacNeal described in detail the symptoms of migraine; and the differential diagnosis between it and chronic sinusitis, brain tumor, and hypertension. Treatment was discussed at length. Octin is the drug of choice. As strange as it seems, pregnancy gives complete relief, but unfortunately headaches return after parturition.

In the discussion which followed, practically all the members present took part.

It was a very enlightening and well-presented speech.

CAMDEN COUNTY

Joseph C. Lovett, M.D., Reporter

Regular meeting of the *Camden Cuonty Medical Society* was held January 8, 1946, at the Camden City Dispensary with DR. HENRY B. DECKER, President, presiding. Fifty-two members and guests were present.

DR. WILLIAM M. LASHMAN took the oath of membership and signed the roll. DR. CLARA HORNER-RODGER, a member of the Society no longer in active practice, was proposed for honorary membership by Dr. Beulah S. Hollinshed and Dr. Joseph E. Roberts, Jr. Applications for active membership were received from Dr. A. Joseph Hughes and Dr. James P. Harbeson, III.

DR. PAUL M. MECRAY, JR., addressed the Society on amebic dysentery and other medical and surgical highlights of his experience in the Army Hospital in Assam, India. He stated that sulfadiazine was the most effective treatment for amebic dysentery. He listed a number of cautions learned in military surgery:

"Never use a gauze bandage to hold a dressing under a cast. It will shrink and act as a tourniquet. Never use a plaster splint if a cast can be made. Never let wounds heal by granulation and epithelization, if possible to do secondary suture or skin graft. Never use gauze bandage as substitute for Ace bandage or plaster on pressure dressing of burn. Never leave any part of extremity uncovered distal to a pressure dressing."

Dr. Mecray advised immediate debridement for intestinal perforation caused by high velocity missiles.

Drs. Sharp, Wilson, Stephenson, Manning Clarke and Coburn discussed the paper. All agreed that carriers of ameba are likely to bring amebiasis into local civilian practice.

Second speaker was DR. E. A. Y. SCHELLENGER, who reviewed his obstetric and gynecologic experience in an Army Hospital in Egypt. He reported many

cases of menstrual disorders—usually psychogenic amenorrhea. Only three cases of gonorrhea were seen which were verified by smears. No malignancies were encountered. The obstetric work was all among wives of soldiers. Most of the deliveries were normal, although there was one ruptured ectopic pregnancy and one pre-eclampsia. Dr. Lee and Dr. Davis commented on the paper.

Dr. H. W. Jack reported that the committee on Veterans' Administration affairs advocated a local full-time Veterans' Administration physician to examine all veteran patients, to advise on further special examinations and to refer the veteran to qualified local practitioners who would treat the patient on a fee basis on a par with regular civilian work. A committee of the Society is urged to censor the work. The plan was criticized by Drs. Sharp, Lewis and Shipman, but the committee was thanked for its report.

Dr. Thomas B. Lee reported for the Trustees that the Kaighn Avenue property owned by the Society is in process of sale. A letter was read from Dr. Lee Griscom thanking the Society for the certificate commemorating fifty years of medical practice.

The chair welcomed the following recently returned service physicians: Drs. Del Duca, Hemphill, Drossner, Stephenson, Price and Stein.

CAPE MAY COUNTY

C. W. Way, M.D., Reporter

A regular meeting of the Society was held December 18, 1945, at The Colony, Woodbine, N. J. The address of welcome was given by Dr. C. W. Way of Sea Isle City. The guests and visitors were introduced by Dr. John Townsend of Ocean City. Dr. Charles Butcher and Dr. A. J. Friedland were present from the Cumberland County Medical Society, and Dr. Clyde Fish and Dr. Baxter Timberlake from the Atlantic County Medical Society.

The guest speaker, Edward Johnstone, Superintendent of The Colony, spoke on *"Trends in Provisions for the Mentally Deficient."* Mr. Johnstone traced the history of our attitude toward mental deficiency from the Spartan practice of disposing of them in infancy to the modern philosophies which provide custodial care for the more severe types and training for return to their communities for those who can make some social adjustment. The speaker outlined the programs of care in the United States and pointed out that the original emphasis had been on the "protection of society by the permanent incarceration of the defective." At that time there was no scientific method for appraising intelligence, and it was not until the early part of the 20th century that psychometric tests came into much use. Following the formulation of these tests, it became apparent that a large proportion of the population was technically "inferior," and that it would have been impossible to place them all under institutional care. As a result many other programs were developed. Mr. Johnstone reviewed present methods and trends and described an up-to-date state program. He declared that such a program should include the following points:

1. Better and more generally available facilities for identification of the mentally deficient.
2. Establishment of a central administrative and coördinating agency to integrate facilities for planning, supervision and care.
3. Specialization of institutional services for those requiring such care.
4. Expansion of home and foster-home programs.
5. Increased emphasis on the responsibility of the public school system.
6. A policy of education to promote better public understanding of the entire problem.

The speaker underscored the fact that there was a place in industry and in society where many mental defectives could make good adjustment but that it was necessary for the public generally to accept individual responsibility in meeting the problem. He urged doctors to be perfectly frank with parents of mentally deficient children in acquainting them with the fact that their children were so afflicted.

The address was discussed by Dr. A. J. Friedland, Dr. Ida Monosson and John Friel.

The meeting was presided over by Dr. C. W. Way, Secretary of the Cape May County Medical Society.

A very delightful buffet supper was served at the close of the meeting in the Colony Club.

A regular meeting of the *Medical Society of Cape May County* was held at the Shore Memorial Hospital, Somers Point, January 22 at 9:00 p. m. The meeting was presided over by Vice-President J. S. D. Eisenhower of Wildwood. Harold Hughes was elected Treasurer. Dues for 1946 were set at $25.00 for each member. Five new members were elected, viz. Isadore Markowitz, West Cape May; James Snyder and Harold Hughes, Cape May City; Marcus Fath, Wildwood, and Paul Yingling, Ocean City. Dr. David Allman, representing the Atlantic County Medical Society, was present as a guest and invited our Veterans Committee to meet with the Atlantic County Veterans Committee for further discussion on that important subject. The committee of C. W. Way, C. Paul Cameron and Paul Yingling will go to Atlantic City for the meeting. There were many visitors present. Dr. Leo Green of Atlantic City presented a moving picture, "Passport to Health".

A buffet supper was served at the close of the meeting at 11:00 p. m.

ESSEX COUNTY

Anthony Ambrose, M.D., Reporter

The *Essex County Medical Society Council* met on Tuesday, December 19, 1945.

The Secretary, Dr. Greifinger, read a letter from Mr. Norman Richman, Personnel Director of Kresge's Department Store, Newark, stating that the Personnel Department is interested in establishing a blood and plasma bank for all Kresge employees and their immediate families and would appreciate any information or assistance the County Society might be able to give them. Dr. Crecca stated that he had answered this letter informing Mr. Richman of everything our Central Blood and Plasma Bank Committee has accomplished to date.

Dr. F. C. Weber, Chairman of the Advisory Com-

mittee to Medical-Surgical Plan, reported that the plan is having difficulty getting doctors to respond to calls for the indigent sick. Dr. Weber also stated that they are working out a plan whereby the doctor will be paid a higher fee per call. Dr. Crecca, for the Central Blood and Plasma Bank Committee, reported that the committee had a meeting with the Freeholders which was very successful. The Freeholders requested Dr. Crecca to submit an itemized statement of everything needed for the establishment of a central blood and plasma bank in Essex County. This statement will then be examined and discussed at the January meeting of the Board.

Dr. H. A. Murray, chairman of the Child Welfare Committee, reported that he was aware of various opportunities in the Health Department for veteran physicians and that the returning physicians should be informed of these opportunities. It was decided that this matter be brought to the attention of the Rehabilitation of Veteran Physicians Committee.

Dr. Greifinger, Chairman of the Medical-Legal Testimony Committee, stated that this Committee had a very successful dinner meeting with the Judges of all the courts in Essex County. The Judges were impressed with our objectives and intentions and assured the Committee of their cooperation. It was decided that the Judges who did not attend the meeting be notified of the action the Committee is contemplating so that the Committee may receive their coöperation.

Dr. Royal A. Schaaf, Public Relations Chairman, reported that the Committee felt that it would be commendable for the Society to pay for a public announcement to be published daily in the Newark Evening News of the names of all the veteran physicians. The cost of the announcement would be $67.20 for one day for twenty names, additional names to be published each day until all names have been published. It was moved that the Society publish a list of twenty names of returning physicians daily until the list of 140 names is complete. A vote was then taken and it was so ordered.

Dr. G. I. Cetrulo of the Post-Graduate Instruction Committee outlined two schedules of contemplated courses to be given by the Committee. One was for veteran physicians and the other for members of the Society. It was agreed that these courses be given publicity by postcards and that the Committee be guided by the replies received.

Dr. Scott informed the Council that since the Government was not thoroughly satisfied with the progress the medical profession has made in relation to establishing clinics for the Veterans Bureau, where civilian physicians would be doing the examinations and be paid on a fee-for-service basis according to an approved schedule, it has decided to establish clinics under its own auspices. Dr. Scott stated that it is a question of whether the medical profession wants to undertake this work or wants the Veterans Administration to take it over completely. A motion was passed that the Medical Society coöperate with the Veterans Administration and help set up these clinics.

MIDDLESEX COUNTY

Alfred J. Barbano, M.D., Reporter

The January meeting of the *Middlesex County Medical Society* was called to order by the President, Dr. C. Howard Rothfuss, at 9:15 p.m., January 16th, 1946. There was a noticeable paucity of members. Minutes of the December meeting were read by the Secretary, Dr. Malcolm M. Dunham, and approved.

The President introduced the guest speaker of the evening, who was Bacon F. Chow, Ph.G., of the Squibbs Institute for Research, New Brunswick, formerly Associate Professor of Biochemistry at the Rockefeller Institute, Peiking, China. The speaker presented a very thorough and learned paper, illustrated by lantern slides, on "Plasma Protein Regeneration Following Oral Administration of Protein Hydrolysates". Results in both humans and animals were presented by Dr. Chow and much of the work done by Dr. Co Tui and his co-workers in New York was tabulated. The speaker also illustrated the comparable results obtained by the analagous product of other pharmaceutical houses. Dr. Chow credited the clinical application to Drs. Faulkingham, Marshall Smith, Allison and Cole, the two latter men being members of the Rutgers Research Council and responsible for much of the clinical laboratory data.

Dr. R. J. Faulkingham discussed the use of protein hydrolysate in five cases, in all of whom good end results were obtained. Dr. Marshall Smith stressed the importance of the hydrolysate in pre and post operative care especially where blood plasma protein was obviously depleted. Healing is apparently enhanced in surgical cases fortified with protein, even decubiti heal in short order. Dr. S. G. Berkow, who has done considerable work on blood protein while in the navy, referred to its usefulness in burn cases. Many facts were added from the floor.

On recommendation of the Ethics Committee Chairman, Dr. F. M. Hoffman, Dr. Benjamin Jackobson, 187 Livingston Avenue, was elected to two years' Associate Membership, as was Dr. William R. Finnegan, 265 Handy Street, New Brunswick.

The following Veteran Members were reinstated to active status:

Dr. Howard Dieker, South River
Dr. Murray B. Jacobson, Perth Amboy
Dr. C. T. Steffens, Dunellen
Dr. Rene G. Schirber, New Brunswick
Dr. Cyril I. Hutner, Woodbridge
Dr. Irvin J. Fine, Perth Amboy

The President read a letter from the State Society re the Delegates to the State Nominating Committee. The matter was referred to the Nominating Committee until next month.

Dr. J. H. Rowland reported on old age relief. A motion was proposed and unanimously carried that all members of the Society coöperate in the old age relief program.

The president introduced Dr. Norman Scott who spoke on veterans' medical care under the G. I. Bill of Rights. There was distributed among the members a summary of the veterans' medical care plan

of New Jersey, presented to the Welfare Committee of the Medical Society of New Jersey, to be submitted to the United States Veterans Administration, Washington, D. C. Dr. Scott requested a motion to coöperate with the State Society plan. He elucidated on several phases of the plan and there ensued a heated discussion lasting far into the night. Among the proposals was a motion that a letter be distributed to each member requesting his participation. Dr. Faulkingham proposed a special meeting to decide on coöperation with the State Society Plan. Dr. Rowland moved that the Society go on record as coöperating with the State Society Plan. Finally a motion was entertained that a special meeting be held to decide Dr. Scott's proposal.

The meeting adjourned at 12:30 a.m.

PASSAIC COUNTY

J. R. Budd, M.D., Reporter

Regular meeting of the *Passaic County Medical Society* was held at the County Administration Building, Paterson, at 9 p.m., December 18, 1945, with Dr. Howard H. Nye, president, presiding.

Speaker of the evening was Dr. Stanton M. Hardy, Medical Director at the Lederle Laboratories, Pearl River, N. Y., whose subject was "Treatment of Hyperthyroidism with Thiouracil". Dr. Hardy's paper was exceptionally interesting and educational, giving the pharmacology, clinical use, indications, administration and dosage, and toxicity of thiouracil in the treatment of hyperthyroidism. His paper was extensively discussed by the members.

At the business session, the following change in the By-Laws was proposed as having the approval of the Executive Council:

Chapter V. Section IV.

Delete entire Section IV, which reads as follows:

> The Secretary of the Society shall be paid for his services the sum of fifty dollars ($50.00) per year, to be paid to him by the Treasurer at the annual meeting, and acknowledged by him in writing. The Treasurer and clerks of sections shall be paid for their services by the remission of their annual dues. If any section lapses into inactivity, its clerk shall not be entitled to such remission.

This received the approval of those present and voting and will be brought to final vote at the January meeting of the Society.

The following were elected to membership:

Active—Harriet N. Stein, M.D., 620 Ridge Road, Lyndhurst; Ward C. Denison, M.D., 316 Broadway, Paterson; Albert W. Greenwell, M.D., 6 South Brookwood Drive, Montclair; William H. MacGahan, M.D., 1 Main Street, Butler; Vincent Feliciano, M.D., 33 North Eighth Street, Paterson.

Associate—Paul Grossbard, M.D., 211 Lexington Avenue, Passaic; Arnold Schleifer, M.D., 10-04 River Road, Fairlawn.

The meeting then adjourned.

FULL-TIME POSITIONS WITH V. A. NOW AVAILABLE

Veterans Administration announces openings for Rating Specialists, a full-time position for M.D.'s which pays a minimum salary of $5092 for a 48-hour week and $4300 for a 40-hour week. This work requires the attendance of the doctor at the Regional Office in Lyons, but it is hoped that some time in March, the office will be moved to Newark. Physicians interested should write to Mr. William Keller, Adjudication Officer, Veterans Administration, Lyons, N. J.

Mr. Keller promises speedy processing of all applications and, while the physicians will enjoy all the benefits of Civil Service, there will be no delay in effecting appointment.

U. S. P. H. S. WANTS DOCTORS

Physicians are now being accepted for duty with the United States Public Health Service both in the Reserve and Regular Corps. Pay and allowances are identical with those for medical officers of the Army. The Service offers a unique variety of clinical opportunities in research, tuberculosis, venereal diseases, mental hygiene and public health. Physicians interested are advised to write to the Surgeon General, USPHS, Washington, D. C.

OVERUSE OF PENICILLIN

New Jersey practitioners are reminded that penicillin is a scarce drug and should be used wisely and only where indicated. This caution is published at the request of the Board of Health and by direction of the Board of Trustees of this Society.

WOMAN'S AUXILIARY

PRESIDENT'S ACTIVITIES

October 8, 1945, to January 14, 1946

Mrs. William E. Dodd

We stand today on the threshold of a New Year, at the cross-roads of Medicine, half way down the path of the 19th year of the existence of the Woman's Auxiliary to The Medical Society of New Jersey.

Your President's activities have been many since last reported in October and have been greatly enjoyed. On October 9, an unsuccessful attempt was made to reorganize the Cape May County Auxiliary. Visits were made to Atlantic County on October 12, Passaic on October 15, and Essex on October 22. Your President-Elect, Mrs. Frederick G. Wandall, accompanied me on this last visit. In each Auxiliary there was an abundance of hospitality and many manifestations of activity and interest. It was an honor to represent you at the Presidents' Day of the Contemporary of Newark on October 23 and to attend their Health Forum on November 20th which was planned by a member of the Essex County Auxiliary, Mrs. John R. O'Sullivan. The discussion on "Rheumatic Heart Disease" revealed the importance of a better understanding of this condition from both medical and economic viewpoints.

Second Annual Conference of Presidents and Presidents-Elect of the Woman's Auxiliary to the American Medical Association met in Chicago on December 5 and 6, 1945. Mrs. Gerald E. McDonnel, National Finance Chairman, and I attended the busy two-day session. Able speakers presented latest information on pending legislative bills involving medical care. Most of the State Presidents and Presidents-Elect were there to discuss their problems and new projects.

These suggestions were of interest to me and could be used very effectively by our Auxiliary, both State and County, namely:

1. That you personally make contact with your Congressman for a "man to man" talk on legislative matters. This will have more effect than a letter.
2. That more than 17 per cent of the national income would be needed to finance the new Wagner-Murray-Dingell Bill.
3. That State Presidents and State Legislative Chairmen will receive up-to-date information on medical legislation directly from Washington.
4. That interest in Auxiliary meetings was increased by offering attendance trophies.
5. That Virginia holds a Council of Presidents of all Woman's Organizations in the state. This meets monthly to hear all pending and passed bills.
6. That benevolence funds for physicians and their families are sustained through memorial gifts to the fund at the time of death in place of the customary floral expressions of sympathy.
7. That the House of Delegates of the American Medical Association, meeting at the same time, passed a resolution, the second in the history of our Auxiliary, requesting the Woman's Auxiliary "to use every avenue possible for widespread dissemination of knowledge concerning the hazards of unrest medical legislation". *We must not fail this appeal.*

The privilege was mine to represent you on January 8 at a meeting of the Woman's Auxiliary to the Philadelphia County Medical Society at which time awards were presented to physicians who had served for fifty years.

Your President met with the Convention Chairman and her Committee in Atlantic City on January 2; with the Secretary and the Archives Chairman on January 9, with the Chairman of our Advisory Committee, Dr. William E. Dodd, and the Public Relations Chairman, Dr. Samuel Sica, on January 13. Visits are planned during February to Burlington, Camden, Gloucester and Somerset.

It is with regret we note the passing of several members of the State Society who have been closely associated with the Woman's Auxiliary and whose wives are active members. In October sincere sympathy was extended to one of our Directors, Mrs. Frank A. Bien, and just recently to Mrs. Andrew F. McBride.

"Beautiful life is that whose span
Is spent in duty to God and Man;
Beautiful calm when the course is run;
Beautiful twilight at set of sun;
Beautiful death, with a life well done."

JANUARY EXECUTIVE BOARD MEETING

MRS. L. MANCUSI-UNGARO, Publicity Chairman

Dr. Samuel Alexander, President of The Medical Society of New Jersey, at the dedication of the Auxiliary Room in the Society Headquarters, Monday, January 14, said that all members of the Society were vitally interested in the health and care of the people of New Jersey. They feel that the public should have adequate medical care at a price they can pay and that the doctors are in the best position to determine the medical care needed and what the cost should be. An acute problem facing the profession today is that of the care of the veteran returning with service-connected disabilities. The Veterans' Hospitals find it physically impossible to take care of these men at this time, and Organized Medicine has been called upon to help solve this problem. The doctors are able and anxious to play their part in coöperation with the Veterans Administration. Public Relations is one of the important phases of the Auxiliary work in which the members of the Auxiliary can be very helpful. Said Dr. Alexander, *"The Auxiliary, through its contacts, can present the viewpoint of organized medicine better than any other group I know of."*

Dr. Alexander was introduced by Mrs. William E. Dodd of Beach Haven, President of the Woman's Auxiliary to The Medical Society of New Jersey, who following Dr. Alexander's speech, accepted most graciously this gift of The Medical Society.

The Auxiliary President then introduced Mrs. C. Chester Chianese of Trenton, Chairman of Arrangements for the day, who in turn presented Mrs. David B. Allman of Atlantic City, junior past-president of the Auxiliary. Mrs. Allman unveiled the portrait of Mrs. A. Haines Lippincott of Camden, first president of the Auxiliary to The Medical Society of New Jersey, to whom is given the name of Mother of Auxiliary and of Auxiliary Work in New Jersey. Mrs. Lippincott then unveiled pictures of the other past presidents, pausing in fitting tribute before the portraits of the two who have passed on: Mrs. James Hunter and Mrs. Frederick Kinch, both of Westfield. Fourteen past presidents were present at this pretty and colorful ceremony.

Mrs. Dodd, as President, was hostess to the past presidents of the Auxiliary, to Dr. and Mrs. Alexander, and to Mrs. Frederick G. Wandall of Clayton, President-Elect of the Auxiliary, for luncheon at the Carteret Club in Trenton.

At the end of the business session of the Executive Committee conducted by its President, Mrs. Dodd, Mrs. A. Haines Lippincott made an appeal that old linen to be used in the making of cancer dressings be sent to the New Jersey Division of The American Cancer Society, 406 Cooper Street, Camden, N. J.

APPEAL FOR SALVAGED LINEN

The program of the American Cancer Society of which the Field Army is a vital part is separated into three divisions: Education, Research and Service.

In New Jersey there is real need for a service program. Many units have been organized to make surgical dressings, bandages, bed jackets, comfort kits and soft bedroom slippers for cancer patients. Most of these articles are made from salvage material, the only exception being the filler for the surgical dressings which is composed of cellu-cotton. This is supplied to local units by the Field Army.

In recent months our supply of dressings has not met the demand. Often one patient will need several hundred dressings a week. We appeal to the women interested in charitable work to start local units for making surgical dressings, etc. The group can be part of an organization or just a small group—four or five—neighbors or friends gathered together in someone's home for an enjoyable time and a worthy cause.

If it is impossible for you to start a unit, you may still lend assistance by sending all your salvage material—sheets, pillow cases, table cloths, or any white or cream colored cotton or linen material; men's shirts, either white or colored, for bed jackets; cretonne, chintz or any material suitable for making comfort kits; bath towels, bath mats and small blankets for making the bedroom slippers. We are desperately in need of these materials, so please help by sending your salvage material to New Jersey Division, Field Army of the American Cancer Society, 406 Cooper Street, Camden, or to your local unit.

KNOW YOUR COUNTY AUXILIARY PRESIDENTS

Mercer County

MRS. H. DONALD COWLBECK

Mrs. H. Donald Cowlbeck was born in Pittsburgh, Pa., but moved to Philadelphia where she attended parochial schools and the Academy of Notre Dame.

In 1929 she married Dr. Cowlbeck while he was doing post-graduate work. They remained in Philadelphia until he finished his Fellowship in Urology at the University of Pennsylvania, moving to Trenton in September, 1931. They have one son, H. Donald, Jr.

Mrs. Cowlbeck is a member of Blessed Sacrament Catholic Church P.-T. A., the Mount Carmel Guild, Red Cross, Trenton Country Club, and the House Committee of Mercer Hospital. For many years she was Chairman of the Arts, Hobby and Medical History Committee of the Mercer County Auxiliary, and is now serving her second year as President. She is State Chairman of Credentials.

During the war Mrs. Cowlbeck was active in civilian defense, having served as block leader, district block leader and air warden.

Middlesex County

MRS. CHARLES F. MERRILL



Mrs. Martha Merrill was born in Jersey City and is a graduate of its public schools. She married J. Alexander Henderson of Jersey City in 1911 and became the mother of a son and daughter, the latter dying in infancy.

In 1915, the family moved to Highland Park, N. J. In 1920, Mr. Henderson died and she and her son Jack returned to Jersey City with her mother.

At this time she attended courses which fitted her for a managerial position in the Indemnity Insurance Company of North America, New York, a position she held for nine years.

In 1930, she was married at St. Mary's P. E. Church of Jersey City to Dr. Charles F. Merrill of Highland Park, Middlesex County.

She became a member of St. Peter's General Hospital Auxiliary, of which she was president 1940-1942.

During this time her husband was president of the Medical Staff at the same hospital.

She became a member of the Woman's Auxiliary to the Middlesex County Medical Society at the time of its reorganization and served as chairman of several committees before becoming president in 1944.

She is a member of the Woman's Club of New Brunswick, N. J., and served as program chairman for several years.

During World War II, she rendered gratuitous service in the U. S. O. as receptionist at Camp Kilmer, N. J., and New Brunswick Chapter of Red Cross in which she is still Staff Assistant.

Ocean County

MRS. CARL H. MENGE



Irene Menge is a Westerner who has made New Jersey her home during the last fifteen years. She was born in Eau Claire, Wisconsin, and was graduated from the Dunn County Normal School in that state. After a brief career as a school teacher, she entered training at the Luther Hospital Training School in Eau Claire, Wis., where she received her certificate and acquired an R.N. in her native state. Moving East in 1928 she met Dr. Carl H. Menge, then an intern at the Kings County Hospital in Brooklyn. The couple were married in 1929 and moved to Toms River, N. J., where they have since lived. Mrs. Menge has been active in the affairs of the Toms River Business and Professional Women's Club, and has twice served as president of that organization. She has held many offices in the Ocean County Auxiliary and was elected president of that Auxiliary last year.

AUXILIARY REPORTS

Atlantic County

Mrs. Samuel L. Salasin, Chairman of Publicity

Plans for coming events were discussed at a luncheon meeting of the *Auxiliary to the Atlantic County Medical Society* held in Atlantic City January 11. Mrs. Robert Bradley, Auxiliary president, extended New Year's greetings to the membership.

The Auxiliary is planning a spring cocktail party for the near future. Mrs. Anthony Merendino, chairman of Ways and Means, heads the committee on arrangements for this affair, assisted by Mrs. V. Earl Johnson.

Mrs. William Roop announced that the next meeting will be at the home of Mrs. Daniel C. Reyner, 17 South Somerset Avenue, on February 8 at 8:00 p. m. An elaborate musical program is being planned, featuring the following artists: Jack Reyner, pianist; Sara Newell, pianist and composer; Mary Nancy Lawler, soprano, and Mary Roop, soprano. Reservations may be made with Mrs. William Roop, 14 South New Haven Avenue.

Mrs. David B. Allman, Public Relations chairman, announced that plans are nearing completion for Health Day on March 8. Topics to be discussed at

the meeting include cancer control, juvenile delinquency and mental hygiene. Invitations will be extended to all women's organizations in the city.

Mrs. Earl V. Johnson was Chairman of Arrangements for a luncheon-meeting at which a lovely multicolored afghan was displayed. This afghan, the work of the mother of Dr. Robert Bradley, will be sent to Red Cross for presentation to a wounded soldier at the England General Hospital.

Camden County

Mrs. Thomas H. McGlade, Chairman of Publicity

Regular meeting of the *Woman's Auxiliary to the Camden County Medical Society* was held January 8 at the home of the president, Mrs. Reuben L. Sharp, Masonville, New Jersey.

Further plans were made for the annual card party to be held at the Walt Whitman Hotel, Monday evening, March 4, 1946, with Mrs. William Braun as chairman. Mrs. Joseph E. Roberts, legislation chairman, announced that Dr. Norman M. Scott will be the guest speaker at the February meeting. Two new members, Mrs. Leslie Angus and Mrs. W. A. Halbeisen, were introduced at this meeting.

Mrs. Max Weimann, State Legislative Chairman, gave a short report on "Medical Legislation as It Is Today".

Eight members participated in the hobby program following the meeting. Particularly interesting were the glass and china slippers owned by Mrs. Braun and the minerals and gems from the collection of Dr. A. Lincoln Sherk, discussed by Mrs. Sherk. Mrs. A. Gomersall Pratt gave a stimulating talk on the activities of her group of Girl Scouts.

A delightful tea concluded the afternoon.

Hudson County

Mrs. Sidney Chayes, Publicity Chairman

The *Woman's Auxiliary to the Hudson County Medical Society* held a regular meeting January 7 at the Young Women's Christian Association, Jersey City. Mrs. Edward Murphy, President, presided. Mrs. Florence Terhune, writer, lecturer and author, was the guest speaker. Her subject, *All Thru the House,* included a demonstration of wall papers and fabrics for Interior Decorating.

Plans were formulated for Reciprocity Day to be held March 4, 1946, at the Women's Club in Jersey City. All organizations and social groups are invited to hear the guest speaker, Dr. Phillip Levine.

Tea was served, and Mrs. Robert Stockfish poured.

Middlesex County

Mrs. Norman Rosenberg, Chairman of Publicity

The January meeting of the *Auxiliary to the Middlesex County Medical Society* took place Wednesday evening, January 16, 1946, at 8:30 p.m. at the home of Mrs. Charles F. Merrill. Following a business meeting conducted by the President, Mrs. Merrill, the Auxiliary carried out the project of the evening, which was the making of cancer dressings.

Ocean County

Mrs. Emanuel Sickel, Chairman of Publicity

The *Woman's Auxiliary to the Ocean County Medical Society* met at the home of our State President, Mrs. William E. Dodd, on January 4.

The treasurer reported that the Auxiliary had $1600 in its Blood Transfusion Fund.

Mrs. Raymond A. Taylor asked for suggestions about a public relations program and most of the members thought that the best topic would be "Medicine's Contribution to Victory". Other proposed subjects were socialized medicine, rheumatic fever, tuberculosis and cancer. It is planned to enlist the coöperation of high schools and have pupils prepare short papers for which the committee would offer suitable cash prizes.

A motion was passed providing that the Auxiliary pay state and national dues of widowed members.

The guest speaker was Mrs. Davendam, who gave a talk on fashions. She emphasized the wide liberty we may enjoy in our selection of styles this spring since it appears now that almost any style sleeve and either wide or narrow skirts may be worn. Mrs. Bavendam predicts that America will replace France as the headquarters of the fashion world.

At the close of the lecture Mrs. Dodd offered us some of the delicacies that she had become accustomed to during her recent vacation in Florida, the acme of which was her pecan caramel pie.

Passaic County

Mrs. Irving Silverman, Chairman of Publicity

At the charity card party given by the *Auxiliary to the Passaic County Medical Society* December 10, 1945, at the Woman's Club of Paterson $1300 was raised for a rheumatic heart foundation in Passaic County. This is the continuation of the project undertaken by the Auxiliary last year, a program which now has the approval of the Freeholders as one of their postwar plans.

With Mrs. T. Vincent Connolly as chairman and Mrs. M. S. Joelson as co-chairman, committees of doctors' wives from every hospital in Passaic County were appointed to further the sale of tickets. Gifts were given for each table, and there were many beautiful door trophies. Mrs. Joseph E. Mott, President of the Auxiliary, was at the head of the reception committee which welcomed the guests of the afternoon.

BOOKS RECEIVED FOR REVIEW

Atlas of Surgical Approaches to Bones and Joints. By Toufick Nicola, M.D., F.A.C.S., with a foreword by Norman T. Kirk, Maj. Gen. U. S. Army, The Surgeon General. Pp. 218, illustrated. New York, The Macmillan Company. 1945. $5.00.

The Extremities. By Daniel P. Quiring, Ph.D.; Beatrice A. Boyle, Erna L. Borouch, M.A., and Bernadine Lufkin, A.B. Pp. 117 with 106 engravings. Philadelphia, Lea & Febiger. 1945. $2.75.

The Clinical Application of the Rorschach Test. By Ruth Bochner, M.A., and Florence Halpern, M.A. 2d ed. Pp. 331. New York, Grune & Stratton. 1945. $4.00.

Manual of Diagnosis and Management of Peripheral Nerve Injuries. By Robert A. Groff, M.D., and Sara Jane Houtz, B.S., with an introduction by I. S. Ravdin, M.D. Pp. 188 with 111 illustrations. Philadelphia & London, J. B. Lippincott Company. 1945. $8.00.

Prescribing Occupational Therapy. By William Rush Dunton, Jr., M.D. 2d ed. Springfield, Illinois, Charles C. Thomas. 1945. $2.50.

Active Psychotherapy. By Alexander Herzberg, M.D. (Berlin), Ph.D. (Berlin). Pp. 152. New York, Grune & Stratton. 1945. $3.50.

Hypnoanalysis. By Lewis R. Wolberg, M.D., with a foreword by A. Kardiner, M.D. Pp. 342. New York, Grune & Stratton. 1945. $4.00.

Modern Psychiatry. By William S. Sadler, M.D., F.A.P.A. Pp. 896. St. Louis, C. V. Mosby Company. 1945. $10.00.

BOOK REVIEWS

Mitchell-Nelson Textbook of Pediatrics. Edited by Waldo E. Nelson, M.D., with the collaboration of forty-nine contributors. Pp. 1350 with 519 illustrations on 333 figures, twenty-six in color. Philadelphia & London, W. B. Saunders Company. 1945. $10.00.

Completely rewritten from cover to cover, this book is not a revision of any previous edition, but its successor. The text has been arranged in double columns, a format which adds greatly to the convenience and comfort of the reader. Too great praise cannot be given to Dr. Nelson's editorship for a job well done. It represents the high standard of pediatric teaching in America today, of which we are all proud.

In line with the trend of modern textbooks, this volume is not written by one author, but by a carefully selected list of eminent authorities. However, a large portion of this work has been contributed by Dr. Nelson, himself. Forty-nine qualified teachers have coöperated. This is ideal since today there is considerable specialization within the field of pediatrics. Certain students, devoting a major portion of their time to a single group of diseases, have been able to acquire knowledge, skill and experience greater than possible to one attempting to cover the entire field. The subject matter is so well integrated in this volume through Dr. Nelson's great skill as to make it appear as though it were all written by a single author.

Among the outstanding features of this book are the excellent illustrations, an appendix consisting of much laboratory data, an exceedingly good section on the anemias of infancy and childhood, a splendid chapter on pediatric allergy, an elaborate discussion of the endocrines, a brilliantly written section on the cardiovascular system, an imposing discussion of the diseases of the nervous system, a thorough analysis of celiac disease, and an exhaustive chapter on drug therapy. There is a section by New Jersey's own Dr. James S. Plant on psychopathologic disorders written in his inimitable and authentic style, which adds prestige to the text.

The entire field of pediatrics is covered, both common and rare maladies. This textbook certainly meets the needs of the undergraduate student and the general practitioner, and it is certainly not too elementary for the well trained pediatrician.

L. Charles Rosenberg, M.D.

The Art of Anaesthesia. By Paluel J. Flagg, M.D. 7th ed. Pp. 519, illustrated. Philadelphia & London, J. B. Lippincott Company. 1944. $6.00.

In this seventh edition of his well known work, Dr. Flagg has added new chapters on the newer technics. Sections are included describing continuous spinal and caudal, refrigeration anesthesia for amputations in poor risk cases, and intravenous pentothal. Ether is still the most widely used agent and the combination of gas, oxygen and ether with the carbon-dioxide absorption method is recommended as the safe and satisfactory routine for inhalation anesthesia. Improved technics of ether anesthesia will lesson and prevent many post-operative complications.

A. C. Bush, M.D.

Pediatric X-Ray Diagnosis: A Textbook for Students and Practitioners of Pediatrics, Surgery and Radiology. By John Caffrey, A.B., M.D. Pp. 838, illustrated. Chicago, Year Book Publishers, Inc. 1945. $12.50.

The author states that, as far as he has been able to determine, no book on pediatric roentgen diagnosis has been published in English during the many years which have elapsed since Rotch's unique volume in 1910. There has long been a real need for an up-to-date work of this type and the reviewer welcomes this splendid book by a well-known authority.

The author's purpose is to present a description of shadows cast by normal and morbid tissues, and clinical appraisal of roentgen findings in pediatric diagnosis. In this he has succeeded admirably. The book is written on paper of good quality and the text is well arranged and printed. There are 711

illustrations, drawings and reproductions of radiographs.

Each section is devoted to some part of the body, namely: the head and neck; the thorax; the abdomen and gastro-intestinal tract; the pelvis and genito-urinary tract; the extremities and the vertebral column. In each, the normal is described and abnormal variations are discussed.

The author is concise yet covers each subject adequately. The index is thorough and practical.

The book deserves a place in the library of any one like'y to have children as patients.

W. James Marquis, M.D.

Modern Psychiatry. By William S. Sadler, M.D. C. V. Mosby Company, St. Louis. 1945. (896 pages.)

This thousand-page encyclopedia of the obvious offers excellent source material for a physician about to give a mental hygiene talk to a lay audience. But it is a weak reed for any doctor to lean on in seeking professional help. The touchstone of any book for the practitioner is surely the applicability of its chapters on treatment. The vagueness of Sadler's therapeutic suggestions empties the volume of any usefulness. "The best way to get over the blues," he writes, "is to enlist the patient in the cheering up business." To the patient with insomnia, the physician is instructed to give advice such as: "leave your worries with your work" and "do no meditative thinking after retiring". Is your patient beset with fears? Dr. Sadler's prescription includes such ingredients as: do not fear fear; do not fight it; do not run away from it. Neurotics are told to "face-up to the normal requirements of living". The "inferiority comp'ex" is treated by: finding the cause and then advising the patient to avoid envy, face the facts, and broaden his interests.

The book is packed with these noble generalities, written in a style admirably suited for an inspirational speaker at a high school commencement.

Henry A. Davidson, M.D.

Pathology of Tropical Diseases. An Atlas by J. E. Ash, Col. M.C., U.S.A., and Sophie Spitz, M.D., C.S., A.U.S. Pp. 350 with 941 illustrations, 15 in color. Philadelphia & London, W. B. Saunders Company. 1945. $8.00.

Despite the many ports of entry into the United States, we have kept remarkably free of tropical diseases. The Public Health Service has done a good job.

But the past few years have seen the global distribution of service personnel to such an extent that every town and village in the U. S. A. will welcome home many who have been exposed to diseases of the tropics. Some physicians will thus renew an old acquaintance, but many more will be introduced to tropical disease syndromes that were formerly only a name in a text-book.

This timely work of Col. Ash and Dr. Spitz marks a decided forward step through a pathologic presentation of each disease together with descriptions of clinical features.

It was timely and fortunate that the Army used a central depository for its material, and that those who were in a position to examine the material were also in a position to study the disease. Result is that the work is complete; so complete in fact that the general practitioner (to whom these exposured persons will first come) will find it makes his most difficult problem, namely, diagnosis, much more simple. As a further aid to the physician not previously familiar with tropical diseases, the book contains area maps. These are of importance to the doctor, who by knowing the tropical area where the patient was billeted, may eliminate those not epidemic or endemic to the area.

The method of presenting the contents is clear, concise, and decidedly time saving. As Dr. E. R. Stitt puts it in the Foreword, "The book is easy on the eyes, and easy on the disposition." The type, the cuts, and most important, the clear readable text makes it so.

This reviewer found the book's last chapter "Ainhum" of equal interest and the cuts as perfect as the earliest in the book.

It is definitely a book of which it may be said, "It is in advance of the times." The book will soon need to be within easy reach of every physician.

Christian P. Segard, M.D.

Approved Laboratory Technic; Clinical, Pathological, Bacteriological, Mycological, virological, Parasitological, serological, Biochemical and Histological. By John A. Kolmer, M.S., M.D., Dr. P.H., Sc.D., LL.D., L.H.D., F.A.C.P., and Fred Boerner, V.M.D. 4th ed. Pp. 1017, illustrated. New York & London, D. Appleton-Century Company. 1945. $10.00.

This revision maintains the great reputation of previous editions as the clinical pathologist's "able first assistant". It opens with a new and much more complete table of contents and in a new style which presents more readily the available material. The book now includes such procedures as estimations of estrin and gonadotropic hormones in urine, penicillin assay methods, sulfonamid determinations, serum enzyme technics, fibrinogen methods, copper sulfate method for specific gravity, Rh factors procedures, and new and complete chapters on such vital subjects as liver function tests, pancreatic function determinations, and vitamin assay methods.

A new section on parasitology capably covers a subject which is both timely and clinically important.

Lester M. Goldman, M.D.

Tuberculosis Abstracts

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XIX **February, 1946** **No. 2**

THE Fourteenth Annual Report of the Tuberculosis Committee of the American Student Health Association records the success of measures to control tuberculosis practiced by progressive institutions of learning in all parts of the country. The results must not be measured solely by the number of cases discovered. In the age group concerned this will always be small as compared to the general population. The search for cases, however, affords a unique opportunity for health education of both faculty and students. The practical demonstration of how to prevent tuberculosis will influence habits of thought and action long after text-book lessons are forgotten. This should make for closer coöperation between patient and physician the country over.

TUBERCULOSIS AMONG COLLEGE STUDENTS

During the past three years there have been many factors which have interfered with the normal functioning of college health services. Yet the number of institutions having to discontinue their tuberculosis programs has been less than was anticipated. The Committee is confident that as our college enrollments return to normal and adequate medical personnel becomes available, we shall witness substantial progress in college health activities.

Many colleges are now planning for expansion which will provide more adequate health programs. The need for this may be better understood from the fact that less than half of the 886 colleges queried replied at all and of the 886 less than a third had tuberculosis programs. It may be safely assumed that those colleges which did not reply were without effective health programs.

The enrollment at colleges conducting case-finding programs in 1942-43 was 406,626. They reported 522 newly discovered cases of tuberculosis, a rate of 128 cases per 100,000 enrolled students. During the past school year, student enrollment at those institutions having survey programs was 286,018. Yet 622 new cases of tuberculosis were diagnosed, a rate of 217 per 100,000. This represents an increase of 19 per cent in the number of new cases of tuberculosis found in a student population which was 30 per cent below that of the previous year and reflects considerable improvement in the effectiveness of case-finding procedures. Of the 622 cases of tuberculosis diagnosed during the year at those colleges having case-finding programs, the lesions were classified as unstable in 156, quiescent in 151 and 315 were designated as healed. At many institutions the original tuberculosis program was frequently limited to entering students, whereas in recent years it has been expanded to include the entire student body.

There are now 93 universities and colleges which are conducting what may be considered practically ideal programs of tuberculosis control. Seventy-four colleges do routine tuberculin testing and X-ray all positive reactors each school year. Nineteen colleges report that chest X-rays are provided for all students annually, they having dispensed with preliminary testing. The programs of both groups of colleges offer a high degree of protection to their students. Cases of advanced tuberculosis among students at these 93 institutions should be encountered very rarely indeed, with such close supervision.

Reports were received from 114 colleges which do not sponsor any type of tuberculosis program. Student enrollment at these institutions was 121,133. There were 14 students found to have tuberculosis, a rate of 12 per 100,000. On the basis of this year's experience, therefore, colleges with case-finding programs diagnosed 18 cases of tuberculosis for each case diagnosed at those schools having no program. Such evidence should leave

no doubt as to the wisdom of employing modern case-finding methods in every college.

The Committee again believes it advisable to emphasize the need for active treatment in the majority of cases of tuberculosis found among young men and women of college age. Of the 622 new cases of tuberculosis among students 73 per cent of all new cases diagnosed during the year were permitted to remain in college. A considerable proportion of this group may experience progression of their disease and will eventually have to undergo treatment. Considerable time may elapse between the development of a new, unstable tuberculous lesion and the appearance of symptoms. Certainly every student who is found to have tuberculosis of recent development should be given the advantage of early treatment. Only when the lesion is judged to be stable and fibrotic is it justifiable to postpone treatment pending a period of observation.

The college which is attempting to protect its students against tuberculosis should give some thought to the possible dangers of non-student contacts. During the year there were 59 cases of tuberculosis diagnosed among faculty members and other employees and 18 cases among food handlers. Since the number of food handlers employed by a college is relatively small in comparison with the student enrollment, no great expense is involved in providing annual chest X-rays for this group.

The Committee believes there is ample evidence to justify the following statements relative to case-finding procedures commonly employed among college students:

1. The incidence of tuberculous infection among college students is steadily decreasing. The majority of reports from colleges in 1943-44 indicate infection rates varying between 15 and 30 per cent.

2. The two-dose Mantoux method is recommended as the method of choice for tuberculin testing. If a single test dose is employed, an intermediate dose of at least 0.1 mg. O.T., or 0.0001 mg. P.P.D. should be used. The Vollmer patch test cannot be recommended for use in colleges.

3. The Mantoux test is highly dependable in eliciting sensitivity due to significant tuberculous infection or disease. It is sound practice, and in the interests of economy, to provide chest roentgenograms for only those students who react to an adequate dose of tuberculin.

4. Complete protection against tuberculosis for college students cannot be attained through a program limited to the student body. Faculty members and employees, including food handlers, should participate in the tuberculosis control program on the same basis as students.

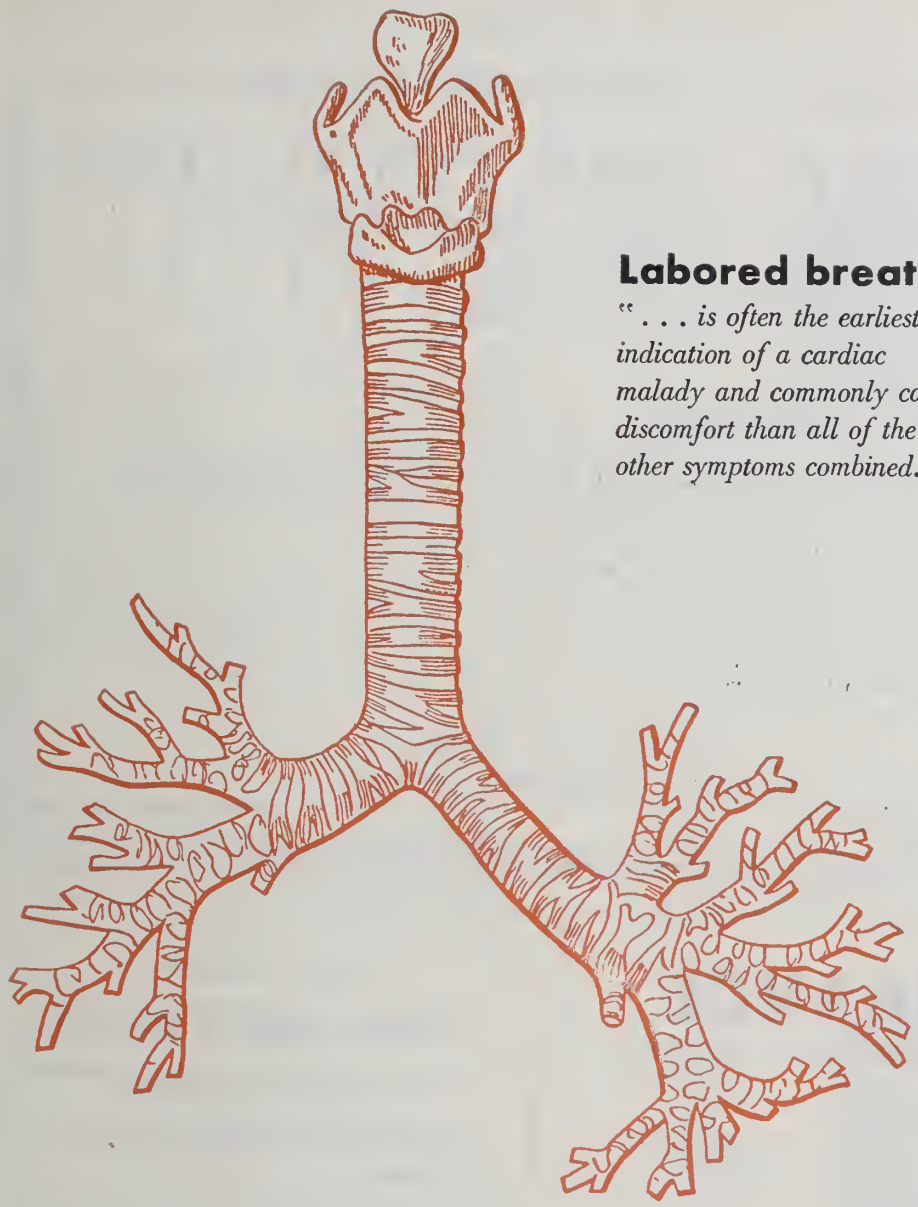
5. The lesions of pulmonary tuberculosis encountered in college students are, in a majority of instances, unstable and potentially dangerous. The absence of symptoms does not preclude the necessity for early treatment. Students who remain in college having pulmonary lesions, should be under close observation with frequent clinical and roentgenographic studies.

Tuberculosis Among College Students, H. D. Lees, M.D., The Journal-Lancet, September, 1945.

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1. *Harrison, T. R.: Cardiac Dyspnea, Western J. Surg., 52:407 (Oct.) 1944.*

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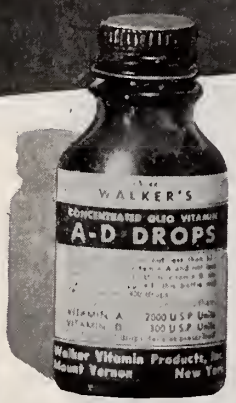
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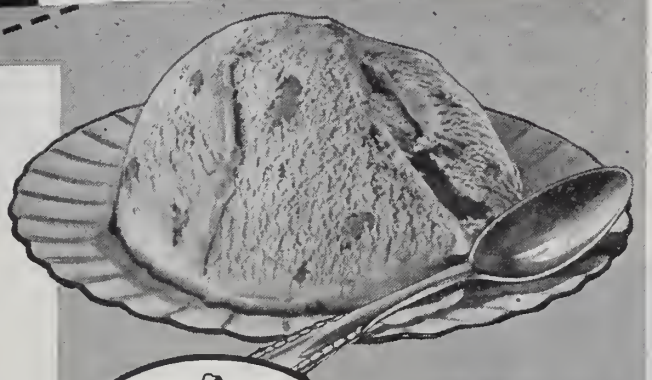
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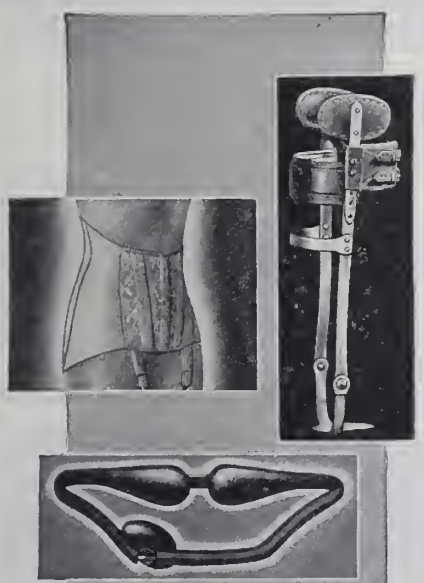
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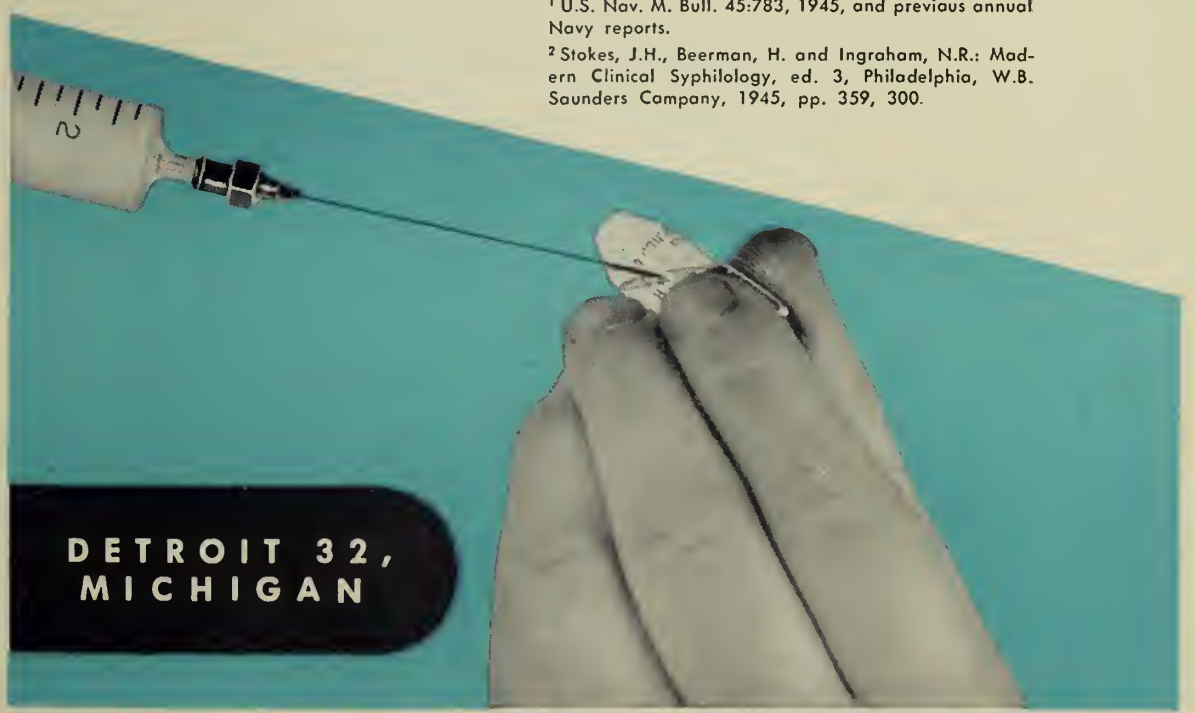
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[1] U.S. Nav. M. Bull. 45:783, 1945, and previous annual Navy reports.

[2] Stokes, J.H., Beerman, H. and Ingraham, N.R.: Modern Clinical Syphilology, ed. 3, Philadelphia, W.B. Saunders Company, 1945, pp. 359, 300.



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*Frazer, J. G.: The Golden Bough, vol. 1, New York, Macmillan & Co., 1923



It is ironical that the practice of attempting to cure rickets by holding the child in the cleft of an ash tree was associated with the rising of the sun, the light of which we now know is in itself one of Nature's specifics.

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THE N.Y. ACADEMY OF MEDICINE
MAY 13 1946

THE JOURNAL

OF

THE MEDICAL SOCIETY OF NEW JERSEY

Place of Publication, Printing and Mailing:
12 SOUTH DAY STREET, ORANGE, NEW JERSEY

Entered as second-class matter, September 5, 1906, at the post office at Orange, New Jersey, under Act of March 3, 1879.

VOL. 43, NO. 3 — MARCH, 1946 — Subscriptions, $3.00 per Year; Single Copies, 30 Cents

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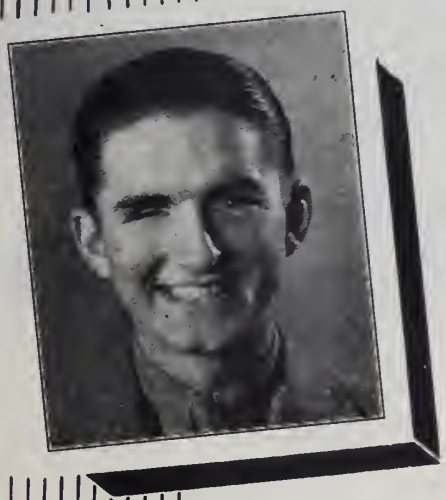
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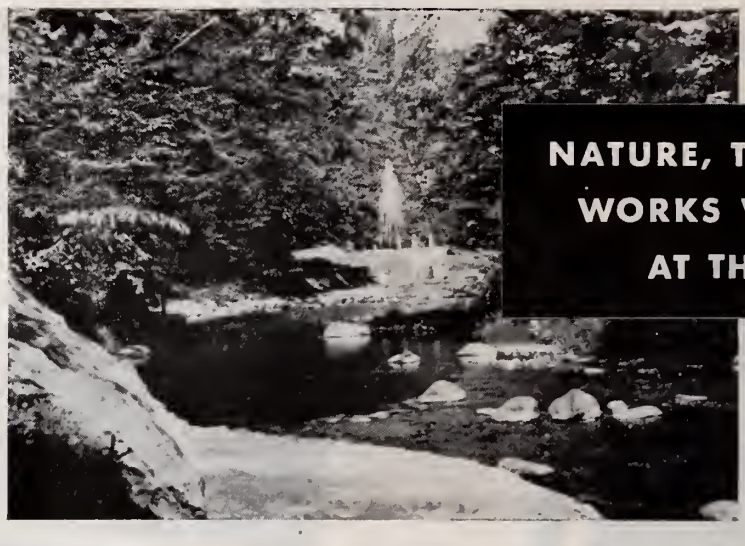
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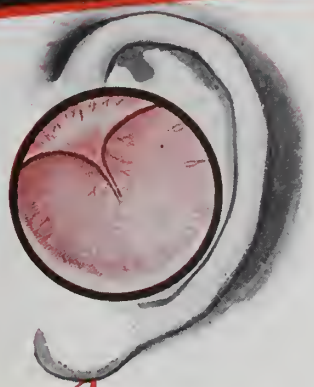
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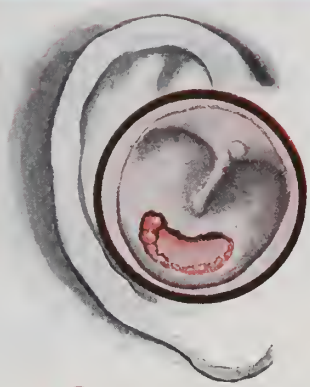
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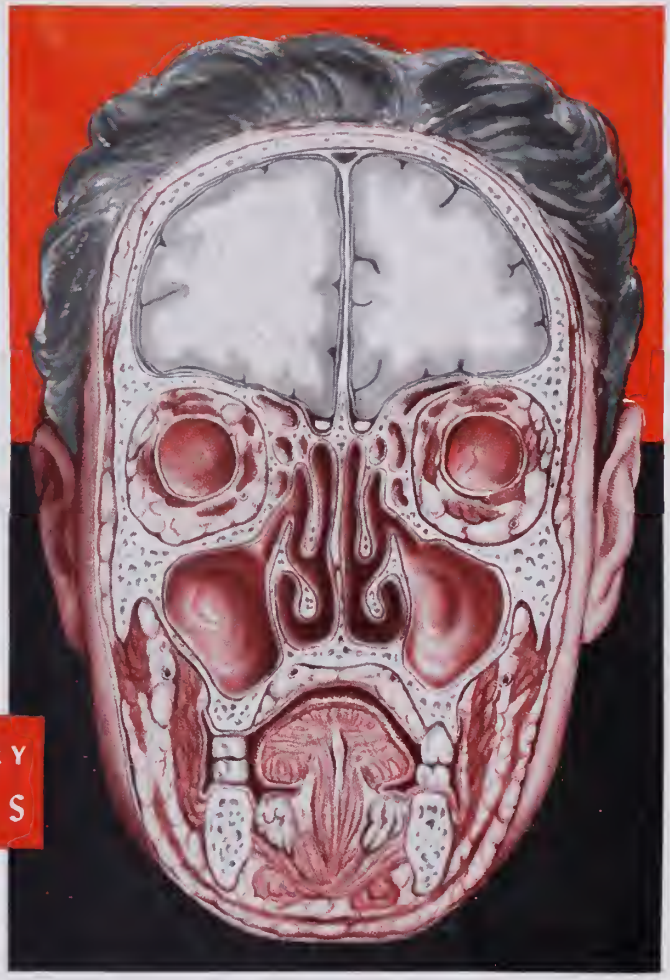
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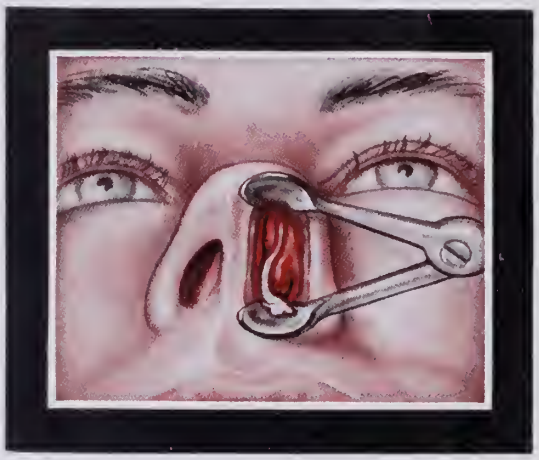
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Growing children require vitamin D mainly to prevent rickets. They also need vitamin D, though to a lesser degree, to insure optimal development of muscles and other soft tissues containing considerable amounts of phosphorus . . . Milk is the logical menstruum for administering vitamin D to growing children, as well as to infants, pregnant women and lactating mothers. This suggests the use of Drisdol in Propylene Glycol, which diffuses uniformly in milk, fruit juices and other fluids.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Pharmacy and Chemistry

DRISDOL IN PROPYLENE GLYCOL

TRADEMARK REG. U. S. PAT. OFF. & CANADA

Brand of Crystalline Vitamin D_2 (calciferol) from ergosterol

MILK DIFFUSIBLE VITAMIN D PREPARATION

Odorless Tasteless Economical

Average daily dose for infants 2 drops, for children and adults 4 to 6 drops, in milk.

Available in bottles of 5, 10 and 50 cc. with special dropper delivering 250 U.S.P. units per drop.

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Pharmaceuticals of merit for the physician • New York 13, N.Y. • Windsor, Ont.



Most DEPENDABLE Method

The combined use of an occlusive diaphragm and vaginal jelly remains, in the published opinions of competent clinicians, the most dependable method of conception control.

Dickinson[1] has long held that the use of jellies alone cannot be relied upon for complete protection. It is noteworthy that in the series of patients studied by Eastman and Scott[2], an occlusive diaphragm was employed in conjunction with a spermicidal jelly for effective results. Warner[3], in a carefully controlled study of 500 patients, emphasized the value of a diaphragm.

In view of the preponderant clinical evidence in its favor, we suggest that physicians will afford their patients a high degree of protection by prescribing the diaphragm and jelly technique.

You assure quality when you specify a product bearing the "RAMSES"* trademark.

1. Dickinson, R. L.: Techniques of Conception Control. Baltimore, Williams and Wilkins Co., 1942.
2. Eastman, N. J., and Scott, A. B.: Human Fertility 9:33 (June) 1944.
3. Warner, M. P.: J. A. M. A. 115:279 (July 27) 1940.

gynecological division

JULIUS SCHMID, INC.

Quality First Since 1883

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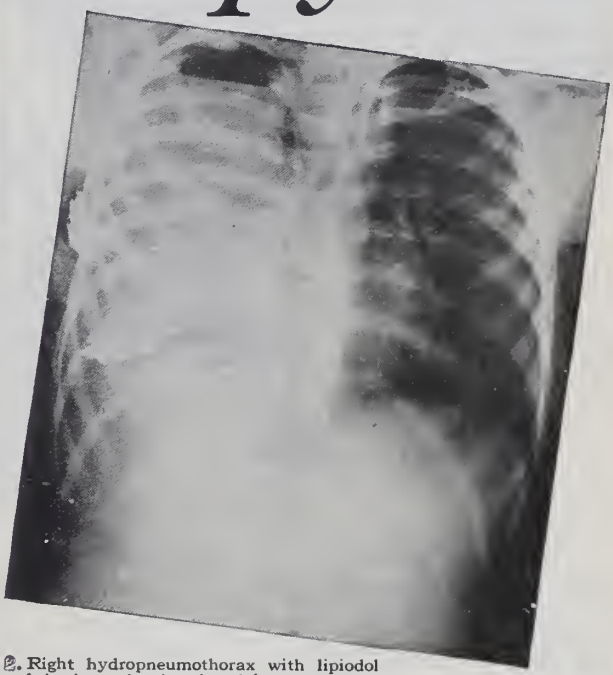
A MARK OF Ramses DEPENDABILITY

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Penicillin in Empyema



1. Right lobar pneumonia (type 1) and right empyema.



2. Right hydropneumothorax with lipiodol injections showing interlobar empyema.

Size of cavity, type of infection, and number of organisms determine the amount of penicillin to be administered in empyema. Usually 50,000 or 100,000 units in normal physiologic saline solution are injected once or twice daily directly into the empyema cavity after aspiration of pus or fluid. (Keefer, C. S., et al.: New Dosage Forms of Penicillin, J.A.M.A. 128:1161 [Aug. 18] 1945.) Treatment is by instillation, rather than irrigation, because penicillin requires at least 6 to 8 hours of contact for maximum effect.

Bristol Penicillin, because of its freedom from toxicity and pyrogens, as well as absolute sterility and standard potency assures the desired pharmacologic action.

The rapidly developing new clinical uses of this potent antibiotic are abstracted in issues of the BRISTOL PENICILLIN DIGEST. If not receiving *your copies* regularly, write.

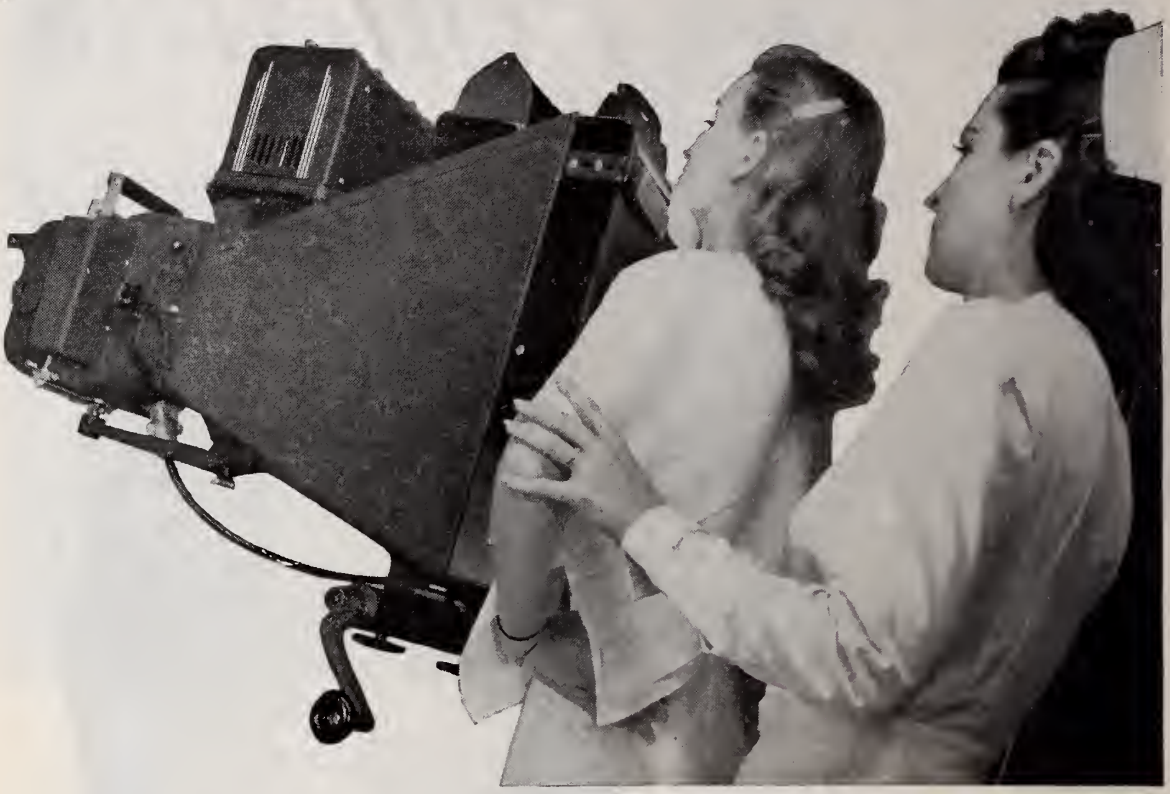
3. After injecting Penicillin in saline into empyema cavity daily for five days.



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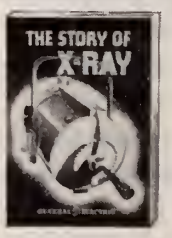
Is Your Community Awaiting an X-Ray Chest Survey?



Through well-directed educational campaigns sponsored by tuberculosis organizations throughout the nation, men, women, and children have been learning about technological developments which today make it economically feasible to conduct x-ray chest exminations of large groups of people for the purpose of detecting unsuspected tubercular infections in apparently healthy individuals.

Public interest having been so thoroughly aroused, many communities have adopted individually planned x-ray chest survey programs as a most effective measure for tuberculosis control—for screening out and isolating individuals who, "ignorant of the fact that they have the disease, unknowingly jeopardize their own lives and the lives of those with whom they come in contact."

Come the time when such a survey is suggested for your community, and your professional advice probably sought by the local tuberculosis society, we shall be glad to help you prepare a summary which would evaluate the various methods and facilities used for different types of chest surveys. These evaluations, may we assure you, will be unprejudiced, as G-E photo-roentgen apparatus is not limited to but one model, nor restricted to the use of one size of film. Address General Electric X-Ray Corporation, 175 W. Jackson Blvd., Chicago 4, Illinois.



For Your Reception Room—this booklet will prove of absorbing interest to waiting patients. It commemorates the 50th Anniversary of the discovery of x-ray, and recounts the notable contributions of x-ray science, not only to medicine but also to many important phases of industry. Send for your complimentary copy. Ask for Pub. C13.

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FORMULAC was developed by E. V. McCollum to fill a long-felt pediatric need for a milk containing sufficient vitamins and minerals to meet the nutritional requirements of a growing infant *without supplementary administration*. The McCollum method of incorporating vitamins into the milk itself eliminates the risk of maternal error or oversight.

FORMULAC, newly introduced on the market, is promoted ethically.

FORMULAC, supplemented by carbohydrates at your discretion, presents a flexible basis for formula preparation, readily adjustable to each individual child's needs.

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*"As a Prophylactic and Therapeutic Agent"**

"There are many opportunities for practical dietary application of the advances in our understanding of protein economy. The provision of liberal protein diets in instances where the value of protein has been demonstrated offers both prophylactic and therapeutic advantages to the patient."

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"Protein is one of the essentials for which there is greater need.... The growth needs of the fetus must be met and if adequate dietary protein is not supplied, the mother's protein stores will be drained.... The demands for protein during lactation are even greater.... One further reason for providing a liberal supply of protein... lies in the favorable effect which protein has upon calcium absorption."

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"... actual improvement in the well-being of nephritic patients may be observed following the use of high-protein diets both in adults and children. In some instances functional capacity of the kidneys has been reported to improve on such a regime.... For the treatment of nephrosis the same dictum holds true, only to a greater extent...."

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"For many years carbohydrate alone has been considered the one substance capable of providing protection for the liver cells. ... Protein has now been shown to be considerably more effective in this respect. ... The effect of protein on the liver is not only reparative, but also definitely protective against the agents known to be toxic to the liver...."

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"... a rather high incidence of moderate hypoproteinemia in peptic ulcer cases has been reported. Any ulcer, be it peptic, infectious, or the result of pressure and circulatory changes, represents a loss of tissue and requires protein for rebuilding...."

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"In old age, for instance, all too often the food intake deteriorates to soft foods of limited variety.... Yet in such instances the same protein requirements for maintenance of the numerous body functions are still in effect.... Protein may also be lost because of its excessive breakdown under the influence of fever or heightened body metabolism, and negative nitrogen balances may develop, as for instance in hyperthyroidism....

"With the demonstration of this increased importance of protein dietetic therapy, it can only be recommended that there be an increased use of high-protein diets."

Among the protein foods of man meat ranks high not only because of the percentage of protein contained, but primarily because the protein of meat is of high biologic quality, applicable for every protein need.

*Anderson, Geo. K., M.D.: *The Importance of Protein in Diet Therapy,* J. Am. Dietet. A. 21:436 (July-August) 1945.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

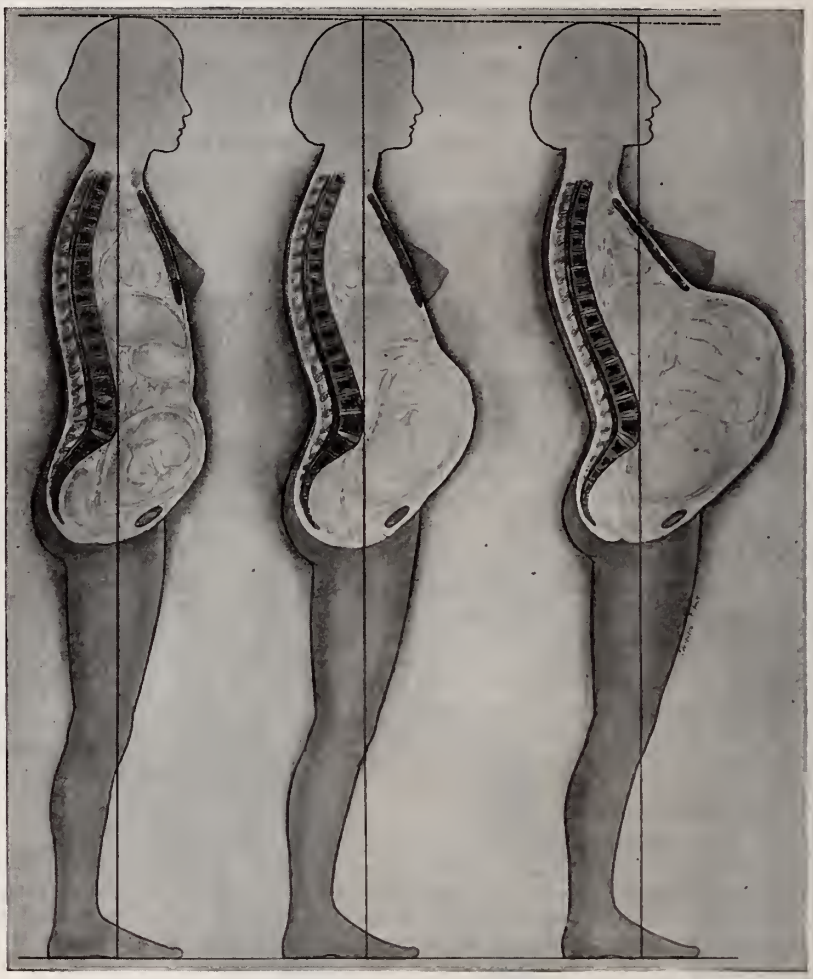
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AMERICAN MEAT INSTITUTE

MAIN OFFICE, CHICAGO . . . MEMBERS THROUGHOUT THE UNITED STATES

BODY MECHANICS OF PREGNANCY

• STUDIES FROM LIFE MODELS DURING PREGNANCY • *Illustration by Charlotte S. Holt*



4 LUNAR MONTHS 7 LUNAR MONTHS 10 LUNAR MONTHS



The postural changes during pregnancy are due to the compensatory backward shift of the center of gravity caused by forward pull of the load of the pregnant uterus.

Note the retracted shoulders, carriage of head (pride of pregnancy), and the accentuation of the natural lumbar lordosis which relieves abnormal tension on back and leg muscles.

Camp Supports aid in reducing this forward traction and assist the mother in maintaining better balance.

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WUENSCH'S 'IMPROVED' HYPOGASTRIC SUPPORT

The 'Hypogastric Support' is considered by many physicians the most efficient of all supports for mild or advanced cases of Visceroptosis. It is especially recommended for the thin, emaciated ptosis figures where most garments would fail to maintain support of viscera without displacement.

Applied in a partial Trendelenberg position in the morning, the 'spring action' of the support, 'moves' the wedge pad with the body . . . maintaining full support just above the pubic bone and preventing the 'slipping' of the organs in back of the pad.

The 'Hypogastric' firmly encircles the body and is not noticeable under the clothing.

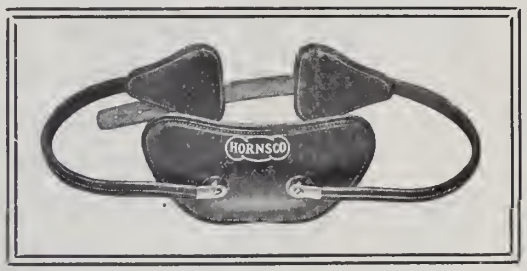
For men and women.



Fitting 'Hypogastric Support' in partial Trendelenberg position.



Hypogastric Support Adjusted



Hypogastric Supports . . . if properly adjusted . . . do not irritate the hip crests. The back pads fit on the fleshy part of the buttocks. The support can easily be worn from morning to night without discomfort to the patient.

Hypogastric Supports . . . are fitted to the requirements of the patient.

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IN INFECTIONS COMPLICATING PREGNANCY, DELIVERY, and the PUERPERIUM

ACCUMULATING evidence* points to penicillin as a therapeutic agent of choice not only in puerperal and postabortive sepsis but also against infections complicating pregnancy (when the causative organisms are penicillin-sensitive). Since penicillin crosses the placenta into the fetal circulation, it may affect penicillin-susceptible infection in the fetus.

*Davis, C. H.: Gonorrheal Arthritis Complicating Pregnancy Treated with Penicillin, Am. J. Obst. & Gynec. 50:215 (Aug.) 1945.

Hudson, G. S., and Rucker, M. P.: Gas Bacillus Infection of the Uterus Treated with Penicillin, Am. J. Obst. and Gynec. 50:452 (Oct.) 1945.

Woltz, J. H. E., and Zintel, H. A.: The Transmission of Penicillin to Amniotic Fluid and Fetal Blood in the Human, Am. J. Obst. & Gynec. 50:338 (Sept.) 1945.

Mitchell, R. McN., and Kaminester, S.: Penicillin; Case Report of a Patient Who Recovered from Puerperal Sepsis Hemolytic Streptococcic Septicemia, Am. J. Surg. 63:136 (Jan.) 1944.

White, R. A.: Puerperal Sepsis Treated with Penicillin, Southern M. J. 37:524 (Sept.) 1944.

PENICILLIN-C.S.C.

These features bespeak the physician's preference for Penicillin-C.S.C.: It is made under rigid laboratory controls which safeguard its potency, sterility, low toxicity, and freedom from pyrogens. The high degree of purification of Penicillin-C.S.C. is indicated by the pale color and small volume of the material in either the 100,000- or 200,000-unit vials. This makes untoward reactions comparatively rare, even when massive dosage and prolonged administration are required.

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FAT	31.5 Gm.	RIBOFLAVIN	1.50 mg.
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*Based on average reported values for milk.



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Write for copies of "Tasty Recipes for Mull-Soy in Milk-Free Diets", for your milk-allergic patients.

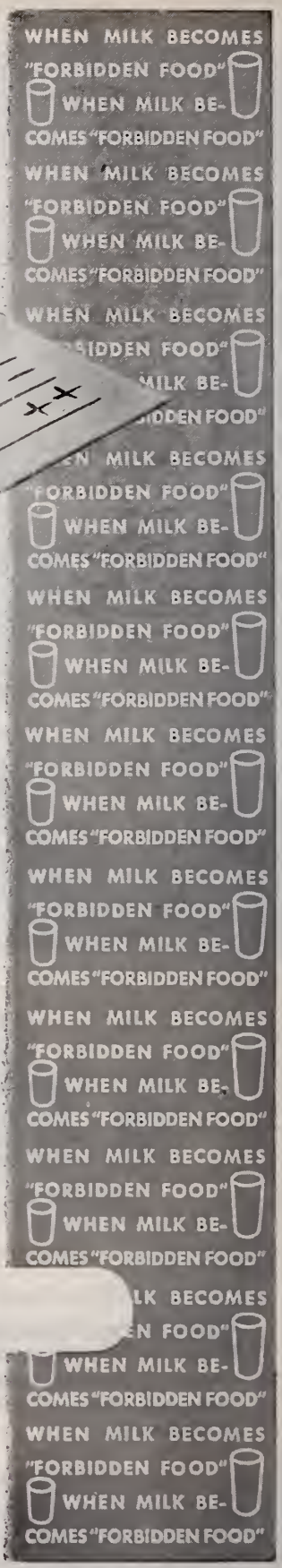
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4. Clinical tests have demonstrated the therapeutic value of Acidophilus Milk in the treatment of constipation of infants and children.*

We believe that it is impossible to buy a more effective Acidophilus—anywhere

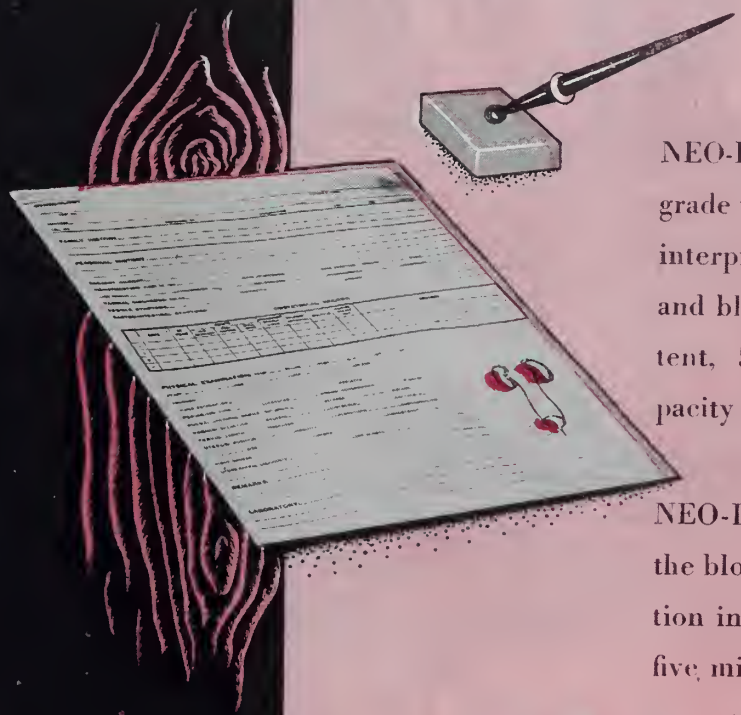
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Acidophilus

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A solution of pure disodium N-methyl-3.5-diiodo-chelidamate, in 50% and 75% concentrations. For retrograde pyelography, a 20% concentration may be prepared by diluting with distilled water.

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Being the powdered leaves made into
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D14



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PURE VITAMINS

—products of Merck Research

Merck & Co., Inc. now manufactures all the vitamins commercially available in pure form, with the exception of vitamins A and D.

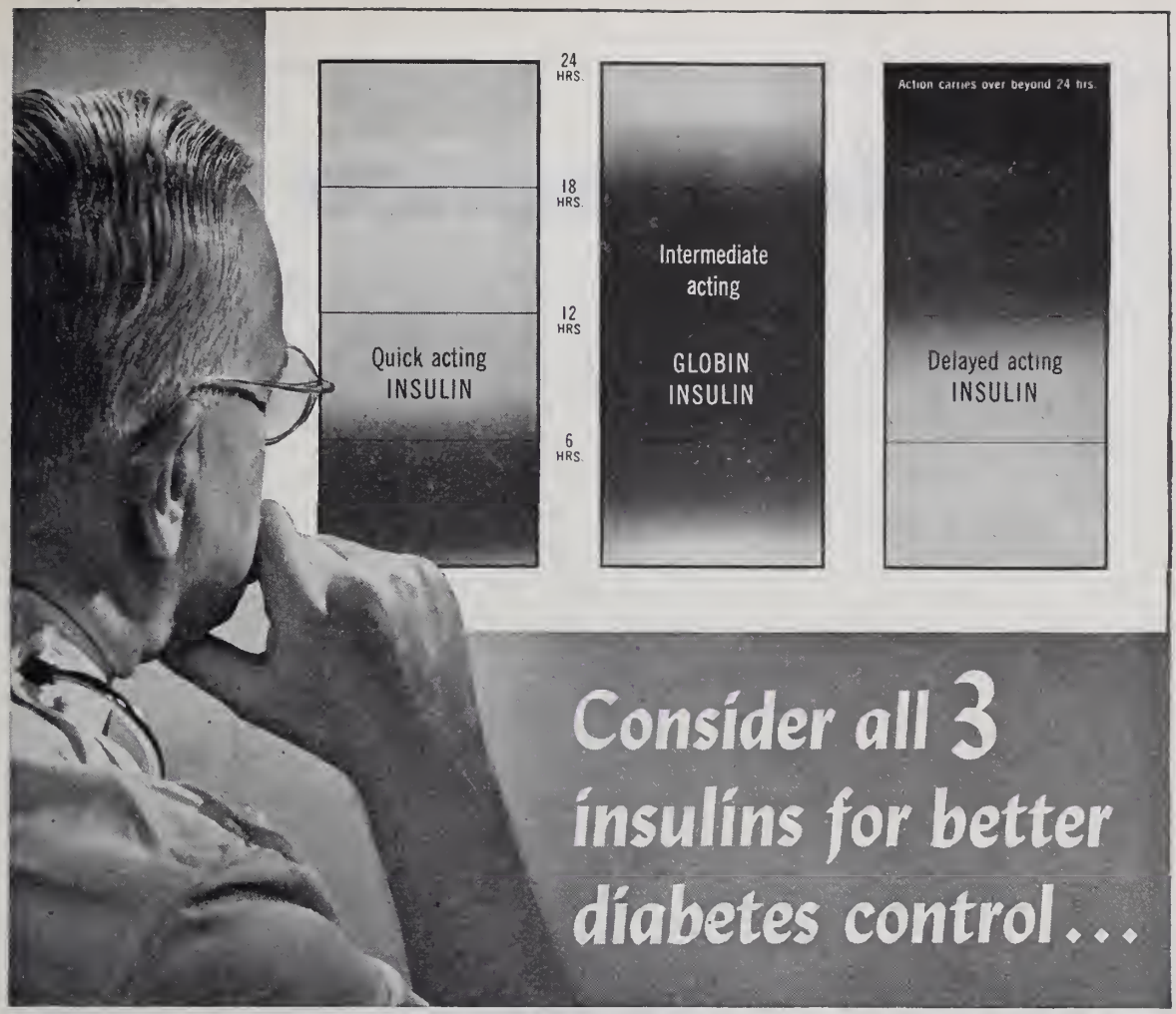
Merck research has been directly responsible for many important contributions to the synthesis, development, and large-scale production of individual vitamin factors in pure form.

In a number of instances, the pure vitamins may be considered to be products of Merck research. Several were originally synthesized in the Merck Research Laboratories, and others have been synthesized by Merck chemists and collaborators in associated laboratories.

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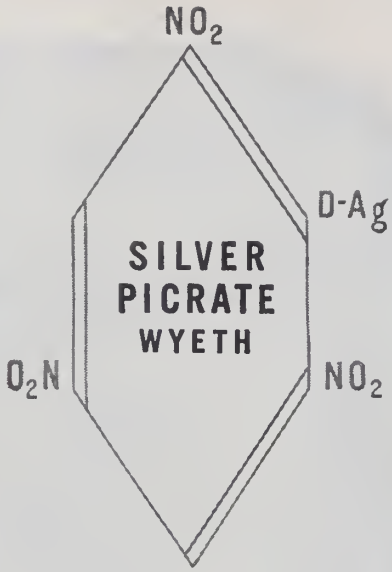
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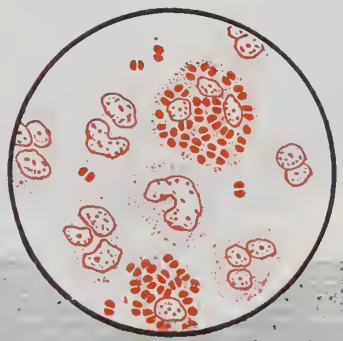
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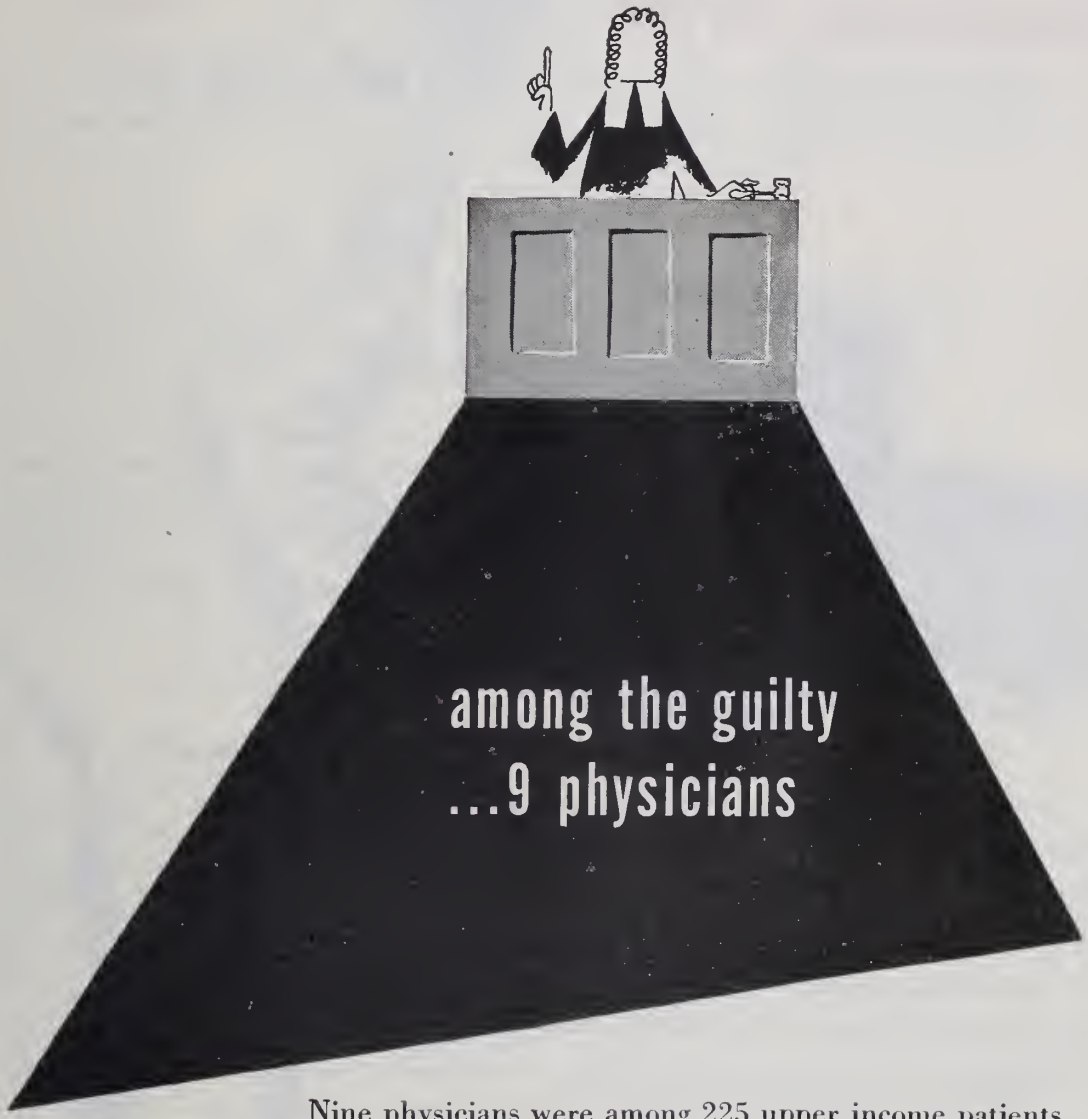
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1. New England J. Med. **228**:118 (Jan. 28) 1943.
2. J. A. M. A. **129**:613 (Oct. 27) 1945.

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OF
THE MEDICAL SOCIETY OF NEW JERSEY

Published Monthly Since September, 1904
Whole Number of Issues, 499

Under the
Direction of the
Committee on Publication

Henry C. Barkhorn, M.D., Chairman

Henry A. Davidson, M.D., Editor

Place of Publication, Printing and Mailing—12 South Day Street, Orange, N. J.
Editorial and Executive Offices of the Society—315 West State Street, Trenton 8, N. J.; Tel. 5776
Each member of the State Society is entitled to receive a copy of The Journal every month.

Vol. 43, No. 3 March, 1946 Subscriptions, $3.00 per Year
Single Copies, 30 Cents

EDITORIALS

TRIAL HEAT FOR ORGANIZED MEDICINE

Disputes about health insurance boil down to the contention on one side that such plans should be controlled and administered by the Government, as opposed to our belief that the medical profession is the best trustee for the direction and implementation of any health insurance project. There has been no large scale experiment which either side can point to as proof of its thesis that Organized Medicine is or is not capable of conducting an extensive administrative project. In the past most of the notable advances in the health of the people have been made through the labor of individual doctors, but much of the promotion and organization has been in the hands of state and national officials.

The proposal that The Medical Society of New Jersey play a leading role in arranging for the care of veterans will effectively test on a state-wide scale the willingness and ability of Organized Medicine to conduct a program which has many administrative and political overtones. If the plan is accepted by the Veterans Administration, it will vest in the organized profession extensive authority in the setting up of examining agencies, selection of physicians, routing of patients and settlement of grievances. If we succeed in giving veterans an adequate program of medical care by doctors of their own choosing, this will establish beyond argument the competence of Organized Medicine to manage major health affairs. If, on the other hand, the counties quarrel as to the relative amount of control which they should exercise, or if there is much bickering about the fee schedule, or if there is an exploitation of the plan by a few individual doctors, or if there should be large scale non-participation by individual physicians—if any of these happen, the public will inevitably assume that the doctors of this state can not be depended on to organize or operate a broad-gaged health program.

The Veterans Plan therefore, represents in a very real sense, a trial heat for Organized Medicine. It is an exceptional opportunity to demonstrate once and for all, the competence of the profession to assume leadership of activities concerned with individual or public health. If we fail, the Government may insist on federalized health insurance; and in their battle to effect such a program, we—the doctors—will have given them their most potent ammunition.

BACK DOOR SUPPLICANTS

One curious by-product of the abnormal war situation has been the appearance in New Jersey of a number of physicians from unapproved medical schools who received internships in good hospitals because of the shortage of physicians. Many of these doctors were later commissioned in the Medical Corps and served with competence and honor. Their plea to be admitted to the examinations of the New Jersey State Board is an inevitable one under the circumstances. Certainly some weight must be given to their contention that if the Army and Navy considered them good enough to practice medicine on soldiers and sailors, they should be entitled to the chance of taking the New Jersey examination. And the fact that they earned certificates of service from approved New Jersey hospitals lends force to their contention.

Nevertheless, it would be hazardous to open the door to these otherwise deserving applicants because of the danger of a precedent that may some day haunt us. Once the bars are let down New Jersey will receive applicants from graduates of unapproved schools who had never served in the Army or Navy but who will point out that their fellow alumni were admitted to the examination and that they have the same professional qualifications. This opening in our Medical Practice Act will be easily widened and each exception to the rule will become a breach through which another applicant may demand special consideration. The medical profession has struggled too hard for its present high-standard Medical Practice Act to allow the structure to be weakened at this time. Exceptions now would lead to a situation in which New Jersey might become a mecca for substandard practitioners everywhere. Our qualifications for practice are admittedly high and rigid. We can not afford to compromise with them.

RED TAPE AND YOUR TAX MONEY

Before complaining about the apparent "red tape" involved in collecting fees under the Veterans Plan, practitioners should stop to consider that this project requires expenditure of government funds. As a responsible member of the community, the physician would be the first to protest the disbursement of public monies without proper authorization. We would look with a jaundiced eye on any government agency which spent money without checking and double-checking the bookkeeping involved. In an effort to provide these safeguards, the government properly insists that authorization and reports be in good form, and this very zeal for the protection of the tax dollar is often considered as red tape.

The Medical Service Administration promises to reduce the clerical details as much as possible and to simplify the reports and bills required of physicians under this project. This it can do only with the understanding coöperation of the profession as a whole.

ORIGINAL ARTICLES

MENTAL HYGIENE PROBLEMS OF THE AGED*

Emil Frankel

Director, Division of Statistics and Research, New Jersey Department of Institutions and Agencies, Trenton

The highest aim of the mental hygiene movement is to help in building a social order which will permit the individual to realize the greatest measure of success within the compass of his native capabilities, which will allow him to enjoy a degree of well-being for effective living throughout the various stages of his life and this surely to include the days of the evening of his life.

Mental hygiene as an organized movement is attempting to set up the machinery through which positive mental health may be promoted and early recognition and treatment be afforded to persons showing signs of mental ill health. These efforts to ameliorate and prevent mental ill health not only concern themselves with the mental life of the young, but with that of adults as well and more recently with the aged who present mental hygiene problems peculiar to the aging process.

An attempt is made here to delineate the mental hygiene problems of the aged in present-day society and to point out some of the efforts which will have to be made and attitudes adopted in order to ensure the aged their rightful place in the social order of today and of the days to come.

THE AGED MENTALLY ILL

Mental illness among the aged constitutes a large and growing public health problem even if based only on mental hospital figures. Such figures admittedly are incomplete, since many aged persons who suffer from mental illnesses associated with old age, chiefly arteriosclerosis and the senile psychoses, are cared for in the community.

First admissions to mental hospitals in New Jersey or elsewhere show an increasing proportion of persons 65 years and older:

	1920	1940	1943
Total first admissions	1743	3271	3375
Persons 65 years and over	230	824	952
Per cent of first admissions 65 years and over	13.2	25.2	28.2

The incidence of hospitalized mental illness among the aged is increasing at a more rapid rate than can be accounted for by the increase in the number of aged persons in the general population of the state. It is shown by the fact that in 1920, 172 individuals were admitted to mental hospitals per 100,000 of the population aged 65 and over, while in 1943 the corresponding rate was approximately 300 per 100,000 of the population aged 65 years and over.

The following table further illustrates the growth in the frequency of mental hospital admissions because of psychoses associated with advancing physical age:

RATE OF FIRST MENTAL HOSPITAL ADMISSIONS PER 100,000 SPECIFIED GENERAL STATE POPULATION

	1920	1940
45 years and over, cerebral arteriosclerosis	19.5	52.5
55 years and over, senile	38.1	55.1
45 years and over, total cerebral arteriosclerosis and senile	38.3	81.8
35-69 years—involution melancholia	1.2	7.1

VIEWS ON PATHOGENY OF MENTAL DISEASE OF AGED

Medical experts give somewhat varying views concerning the pathogeny of mental disease among the aged and the increasing trend of mental hospital admissions among them. Two representative opinions may be cited here. Dr. Samuel W. Hartwell, Professor of Psychiatry and Mental Hygiene, School of Medicine, University of Buffalo, feels that "most of the psychoses developing in the fifth decade or

*Address at Symposium on Some Aspects of Mental Hygiene, Forty-third Annual Conference, New Jersey Welfare Council, November, 1944.

thereafter have an organic basis or at least an important organic factor. These are in the present state of our knowledge, believed to be in the brain. The changes in metabolic and endocrine functions and probably in other bodily functions are often if not always factors." [1]

A different view has been expressed by Dr. Winfred Overholser, Superintendent of St. Elizabeth's Hospital, Washington, D. C.:

Studies of the brains of aging persons indicate that the mental symptoms manifested do not necessarily display any direct relationship to the extent of the structural damage to the brain. The type of personality of the individual and the variety of experiences to which he has been subjected unquestionably are important factors. We must, indeed, look considerably farther than the pathology of the central nervous system to discover why patients in the later years of life require hospital care, although unquestionably a general failing of the bodily functions is a factor in the development of late mental disorder.

The psychological hazards of growing older have been considerably underestimated by physicians and probably by welfare officials, industrialists, and others who deal with problems of the older persons. Recent developments in the field of psychosomatic medicine have indicated clearly the close relationship between emotional conflict and various functional and, indeed, structural changes. This is notably true in conditions of the cardiovascular system. It is thus possible that the psychological hazards have a direct bearing on the development of hardening of the arteries and upon those mental changes which are directly traceable to cerebral-vascular accidents.[2]

CARE OF AGED MENTAL PATIENTS IN HOSPITALS FOR MENTAL DISEASE CHALLENGED

The use of the hospital for mental disease itself in caring for aged mental patients is opposed by many observers who feel that a different type of facility should be furnished. It is difficult in the typical mental hospital to provide appropriate care for aged patients in view of demands of other active treatment patients, and places an unnecessary burden upon the hospital administration.

A newer development suggests that so-called "geriatric units" be established in mental hospitals to meet the special needs of the aged patients. The hospital structure preferably should be of the one-story type so that as many patients as possible can get out of doors. Efforts to provide building and other facilities especially adapted for the aged are now being made by the mental hospitals of New Jersey.

FAMILY CARE OF MENTAL HOSPITAL PATIENTS ADVOCATED

Arising originally out of need to relieve overcrowding in mental hospitals, care of mental patients in family homes under arrangements similar to those by which foster home care of children is provided is being advocated increasingly by mental hygienists. This type of care is considered especially desirable for types of persons such as many aged mental patients represent for whom care in the hospital is therapeutically unsound or economically unwise.

Many patients who do not do well under large scale hospital care flourish in the warmth of family life. Family care often constitutes wholesome therapy because it increases the initiative of the patient and decreases his fretfulness and resentment at the confining atmosphere of the hospital.

For the older patient, arrangements for family care can be made through the State Old Age Assistance Division and the County Welfare Boards. Patients under family care, it should be kept ever in mind, require close medical supervision while social work supervision should be exercised through the social service department of mental hospitals.

SUGGESTIONS TO SOCIAL WORKERS DEALING WITH AGED MENTAL PATIENTS

Social workers dealing with aged mental patients may find many valuable and encouraging suggestions made by Dr. Samuel W. Hartwell:

Psychiatrists need social workers if they are to avoid pessimism as to ever being able to do much about this constantly increasing problem. The most skilled psychiatrist can do no more to help the older person acquire understanding and happiness than can a sympathetic social worker or institution staff member acquainted with the inner world of old age.

The great task of social workers and others interested in the care of the aged is to act as the liaison agent between the relatives and the hospital staff. Relatives badly need the aid of psychiatrists and social workers to help achieve an objective attitude when faced with the social and mental conflicts that occur when some aged member of their family becomes mentally ill.

1. Quotations are from articles printed in "New Goals for Old Age", edited by George Lawton. Columbia University Press. Appreciation is expressed to authors and editor.
2. "The Problems of Mental Disease in an Aging Population." Proceedings of the National Conference of Social Work. Columbia University Press.

Psychiatrists need social workers and others who care for the aged to constantly point out the reality of the total situation when we are giving advice to relatives about the best solution of the problems presented by the individual case.[1]

WHAT IS THE OUTLOOK FOR THE PREVENTION OR POSTPONEMENT OF SENILE MENTAL DISEASE?

The question of whether or not senile mental disease can be prevented is of great concern to all interested in the mental hygiene movement. In this connection it is important to consider three trends which have a definite bearing upon it. Two of these trends relate to the increasing longevity of the population and the increasing urbanization which tend to complicate the emotional problems of the aged, while the third, the social security movement, tends to lessen the fear of want as well as relieving the economic stresses and tensions which cause emotional problems among the aged.

INCREASING LONGEVITY

The life span has been increased by fifteen years since 1900. The average child surviving for one year who was born in 1900 could look forward to 50 years of life. The average child born in 1940, and surviving for one year, had a life expectancy of 65 years. The next generation, in all probability, will have a life expectancy of from 68 to 70 years.

The prolongation of the life span, of course, is the great achievement of the developing science of pediatrics. Preventive medicine and inclusive public health services have controlled many infectious and communicable diseases. Diphtheria, scarlet fever, typhoid fever, and pneumonia, which formerly took a heavy toll among children and young adults, have been virtually eliminated as causes of death.

The effects of increasing longevity are reflected in the composition of New Jersey's population. From 1930 to 1940, the population of the state increased by 119,000 persons. It is to be noted, however, that among persons under the age of 55 years there was an actual *decrease* while at the same time there were increases of 75,000 and 78,000 respectively, among persons 55-64 years, and among persons aged 65 years and over.

Considering the aged (those 65 years of age and over) in relation to the total general population, it may be observed that in 1900 there were approximately 80,000 such persons in New Jersey who constituted 4.2 per cent of the state's population. By 1940, the number of aged persons had more than trebled so that there were 278,000 in the state, constituting 6.7 per cent of the population. Scientific population estimates predict that by 1980 more than 10.4 per cent of the population of New Jersey will consist of persons 65 years of age and older, the probable number of such persons being estimated at between 525,000 and 550,000.

URBANIZATION

The second major trend affecting the welfare and the mental health of the aged is urbanization. With our enormous industrial development, there has been a vast increase in the number of industrial and clerical workers who have crowded into large cities.

This development has had far-reaching influence upon individual living. An ever-increasing proportion of our population consists of small families living in small apartments, rented from impersonal organizations. This stands in sharp contrast to the prevailing economy of small proprietors living in housing which whatever its defects may have been in terms of primitive sanitation and lack of conveniences did provide ample space and where the relatively small numbers of aged persons could depend upon receiving care at home during their declining years.

The changed economic system has also completely altered the individual's relationship to his job. Whereas in the old days the individual tended to think in terms of "making" a living, with implications of creative purpose and satisfactions, now the term is "earning" a living, which implies a greater measure of social stratification, with greater dependence upon wages and with fewer satisfactions to be found in the individual's economic life.

SOCIAL SECURITY

The third major trend of importance to consideration of the problems of the aged is the social security movement which culminated in the adoption, early in the 1930's, of various

measures to guard against destitution in old age.

The old age pension movement in the United States began to take form early in the present century as it became evident that old age dependency was not necessarily due to individual maladjustments but rather to social and economic forces altogether beyond the control of the individual. Modern industrial processes are prejudicial to the employment of older workers. Prevailing levels of wages permitted only a very few individuals, no matter how industrious or thrifty they might be, to save up enough money for economic security in old age.

With more and more individuals surviving to advanced age and with fewer children and limited living quarters so that only infrequently could aged persons expect to rely upon family resources for support, it became obvious that old age dependency was a by-product of our social system and that society itself must provide the resources for the support of the aged.

Motivated by this conviction, New Jersey adopted its first Old Age Assistance Program in 1931. The Federal government entered this field of service in 1935 with the adoption of the Social Security Act. These programs to provide assistance for the needy aged stemmed from the poor relief tradition. They required that the aged submit proof of inability to support themselves.

The importance of these programs may be seen in the fact that in the United States 2,234,000 persons 65 years of age and over received old age assistance during 1941, these constituting 6.8 per cent of the total number of persons 65 years and over in the continental United States. Since 1941, the unusually favorable employment conditions caused by the war have led to a marked reduction in the number of dependent aged persons.

New Jersey's experience closely parallels that of the country as a whole. The highest number of persons who received aid through the old age assistance program was 31,200 in 1941; they comprised 6.7 per cent of the state's 278,000 persons aged 65 years and over.

Old age assistance expenditures from 1933 through 1943 have amounted to more than $3,500,000,000 for the United States as a whole. In New Jersey, over the same period, approximately $54,000,000 has been spent for this program.

While old age assistance programs have been accepted as a community recognition of society's responsibility for the care of the aged, they fall short in one important respect. From a mental hygiene point of view, it is tremendously important that the aged should feel that their support comes not as a form of charity but as a payment for services rendered. The Old Age and Survivor's Benefits program of Social Security, adopted as part of the Federal Social Security Act of 1935, is intended to meet this challenge. Already this program has become a major resource in providing support for the aged. In July, 1944, more than 1,000,000 individuals were receiving benefits from this source, of whom 425,000 were aged individuals while the remainder were "survivors" — widows and dependent children of individuals who were contributing to the program during their last working years.

THE AGED IN A CHANGING SOCIAL WORLD

Apart from the health aspects of the problem, it remains true that the problems of old age are, as has already been stated, increasing largely because of the changing age distribution of our population with a declining number of younger people and a growing number of older people which make adjustments in our social, economic, and political life imperative.

The problems of the older worker in industry were well defined by Dr. Winfred Overholser:

> Until very recently a tendency had been gaining momentum toward the early retirement from industrial life of persons who reach the age of forty-five or thereabouts, so that the age at which a person might feel himself superannuated has constantly been lowered. This not only has tended to result in an actual and well-founded element of anxiety concerning financial independence, but has likewise emphasized a feeling of frustration and of uselessness.[2]

For the mental well-being of the aged, it is highly desirable that industry adopt a forebearing policy toward the older worker and

not force early retirement. Industry should give the older worker a job he can safely do. Workers of advancing years should be shifted from jobs involving speed and strength to those which utilize skills which age does not impair. Medical supervision and direction should be provided to aid the older worker in maintaining himself under modern working conditions.

The opportunities for older workers offered by the war situation have demonstrated that this approach to industrial utilization of the older worker is feasible and reasonable. There remain, however, sound reasons to anticipate that the problems of the older worker may be extremely difficult in the postwar world.

Old Age and Survivors Insurance will eventually cover all workers and their dependents. Speed in the extension of this form of social security may contribute largely to the mental hygiene efforts of providing economic security in old age and may have important influence as a preventive of mental breakdowns through removing the specter of dependency.

Even in cases where mental illness does occur, a small income from old age and survivors' insurance may mean that the patient can be cared for at home in a marginal income family and not be forced to seek hospital admission. Moreover, the "small income would serve as an antidote toward the impatience which the younger generation is likely to feel with the querulent and forgetful aging parent".

Research program development important

The development of a research program devoted to the medical and biologic aspects of old age is today recognized as having fundamental importance. The recognized diseases of old age (geriatrics) require special attention just as diseases of children (pediatrics) do. The geriatrician, a physician specializing in the diseases of old age, may reasonably become as accepted a part of the medical world as is the pediatrician of the present time.

Already, the National Health Institute of the United States Public Health Service has established a Division of Gerontology, a special unit for research in some problems of aging.

Teaching how to grow old

Facilities for teaching people how to grow old can be highly important assets to the mental hygiene of the aged. Individuals who are beginning to feel the effects of advancing years require counseling and many of them can benefit from rehabilitation.

Old Age Centers, such as the Old Age Counseling Center in San Francisco founded by Dr. Lillian J. Martin and directed by her until her recent death, could be of tremendous help in this connection.

As expressed by Dr. Martin, the function of these centers is to assist the aged in adapting their interests and activities to their stage of life:

> What we have come to believe, as a result of rehabilitation work with the aged is that these people are just as subject to change and growth as in any other period of life, allowing always more time to effect the change in old age than in youth or childhood.[1]

The social worker, therefore, can help in the deliberate planning for old age and can participate in developing some more systematic program to foster this preparation for later life.

Our duty to the aged

What old people want "is not idleness and freedom, but an opportunity to do something with their lives that will make them significant".[1] This comment by Lawrence K. Frank represents a truth which is too often overlooked in our efforts to make life "easy" for the aged as it is in the thoughtless disregard of the feelings of the aged which is so frequently displayed in the processes of economic life.

American civilization must begin to value age. One of the finest things we can do is to arouse the conscience of the American people to a sense of moral obligation to old folks, not merely to furnish them with security against economic want, but also to teach people the need of giving understanding and loving care to old people, of making them feel valued participants in family and community affairs.

In this way we can carry out our duty to old people, which is to help them maintain or establish faith in themselves.

MODERN TREATMENT OF PEPTIC ULCER

J. Gerendasy, M.D., Elizabeth, N. J.

Most physicians and surgeons agree that the uncomplicated peptic ulcer is a medical problem. Three distinct phases are involved in the management of peptic ulcer.

The first phase: Control the symptoms, particularly pain. This is accomplished by (a) frequent, restricted food intake of a bland diet (diet 1) chemically and mechanically nonstimulating to acid-pepsin secretion; (b) by complete neutralization of the free hydrochloric acid with alkalin salts until active symptoms subside; subsequently with neutral powders for prolonged effect; (c) control of the neuropsychogenic factors with the aid of a sedative antispasmodic mixture such as atropin sulphate gr. 1/200 with phenobarbital gr. ¼ (t.i.d.a.c.).

The second phase: This is concerned with healing of the ulcer. Rest is of the first importance. Complete bed rest in gastric ulcer; controlled and restricted activity in ambulant cases of duodenal ulcer. Healing is hastened by giving large doses (300 to 500 mg. or more) of cevitamic acid, preferably hypodermically in conjunction with a good concentrate of vitamin B complex. Repeated hot fomentations to the abdomen are also of material value.

The third phase in the treatment of ulcer is the attempt to prevent recurrence. This entails the recognition (by both physician and patient) of the fact the cause of peptic ulcer does not lie in a single factor. It means awareness of constitutional predisposition, elimination of focal infection, especially nasopharyngeal infection, and lastly, freedom from emotional stress, strain and fatigue. This third phase of ulcer management is too often entirely neglected or inadequately stressed by physicians in general. This neglect is due chiefly to a failure to appreciate the fact that ulcer is a chronic recurrent disease. Relief of symptoms does not mean cure of the disease. The word "cure" should really imply permanent control of both the local factors and the other contributing ones, such as unhygienic habits of various kinds.

The dietetic management of ulcer is second in importance only to the regulation of the mode of living of the patient. If symptoms are severe (and especially if there is nocturnal pain), the strict Sippy regime of hourly feeding of milk and cream and Sippy powders, including night feedings, is still the best medical treatment. To this is added tincture of belladonna, 10 drops, t.i.d., increasing to tolerance. In milder cases, diet may be more liberal at the onset (diet 2). When pain is absent and *tenderness on palpation in the epigastrium* disappears, the diet may be increased still further (diet 3) and the antacids changed to neutral powders. The larger dose of belladonna, however, is continued. This treatment, including medication and diet, is continued for at least 6 weeks, the usual *minimum* period for the healing of peptic ulcer. At the end of this time the patient is placed on a standard or permanent diet (diet 4) for an indefinite period and the neutral powders continued for many months.

During the entire treatment period, regulation of bowel function is essential. Simple measures will suffice. A combination of antacid powders, suggested below, having mildly laxative effects or the use of a hydrogel substance, such as agar agar or metamucil, will produce results. Olive oil or preferably mazola oil ½ to 1 oz. twice daily is also recommended as well as an occasional low warm saline enema.

DRUG THERAPY

Carlson in 1916 demonstrated that complete neutralization of the gastric contents by alkalin powders was followed by a rise in the free acid to levels higher than those existing prior to administration of the alkalies. The more the gastric secretion increased, the more irritable the mucosa became and the greater was pyloric and colonic spasm. This vicious circle necessitated the trial of substances to buffer the gastric contents without untoward effects. As a result, there developed the use of neutral pow-

ders, gastric mucin and parenteral therapy (such as intravenous histidine), emetin as well as vaccines and foreign proteins.

The non-systemic antacids or neutral powders recommended are:

1. Magnesium oxid; Magnesium carbonate; Magnesium hydroxid; calcium carbonate; bismuth subnitrate or bismuth subcarbonate.

2. Aluminum hydroxid; Magnesium trisilicate; tribasic magnesium phosphate.

The first group are *absorbents* that neutralize gastric acidity. The second group are *adsorbents*. Their action is a physical one whereby hydrochloric acid is adsorbed and then freed and neutralized in the alkalin intestinal tract. These substances are best used in combinations, such as:

(A) ℞
Magnesium ponderosum
Bismuth subnitrate aa drams 3
Soda bicarb drams 18
Oil of peppermint qs
Saccharrin qs
M. Sig drams ½ after each of 6 meals

(B) ℞
Magnesium Trisilicate 2 oz.
Aluminum Hydroxid 1 oz.
Oil of peppermint qs
M. Sig. drams 1 after each of 6 meals

(C) ℞
Pulvis Bismuth Subnitratis Comp. cum Carbo—Ligni oz. 3
(N. J. F. No. 27)
Sig. Dram ½ after each of 6 meals

(D) ℞
Tribasic Mag, phosphate which has poor neutralizing power may be given in dram doses 4-5 times a day.

(E) ℞
Colloidal aluminum hydroxid may be suspended in water in the proportion of ½ oz. of the powder to 8 oz. of water and prescribed in tablespoon doses 6 times a day.

(F) ℞
Gastric mucin is marketed as gastric mucin powder or granules and acts as a demulcent and adsorbent and is given in doses of 30 to 60 grains every 2 hours. It will often be found effective when the others fail.

Parenteral therapy with histidine hydrochlorid and emetin as well as vaccines and foreign proteins are of questionable value in the modern treatment of peptic ulcer.

Diet 1:
3 oz. milk and cream hourly, 7 a. m. to 9 p. m.
3 oz. fine cereal at 7 a. m., 11 a. m. and 3 p. m.
1 egg at 9 a. m. and noon, 5 p. m. and 8 p. m.
Arrowroot or Uneeda crackers with butter or cottage cheese at 11 a. m., 1 p. m., 3 p. m., and 5 p. m.

Diet 2:

7 a. m.	Juice of 1 orange, strained; oatmeal with cream, 1 slice toast, 6 oz. milk and cream
9 a. m.	1 soft boiled egg, 1 slice toast, 1 tsp. preserves, 6 oz. milk and cream
11 a. m.	1 raw egg with 6 oz. milk and cream
1 p. m.	1 spoon mashed potato with butter, 1 slice toast with butter 6 oz. milk and cream
3 p. m.	Tapioca pudding with cream, 1 slice toast, 1 soft boiled egg 6 oz. milk and cream
5 p. m.	1 egg with milk, prune souffle, 1 slice toast with butter
7 p. m.	Cream of wheat with butter Applesauce, 6 oz. milk and cream

Diet 3:

6:00 a. m.	½ glass orange juice
7:00 a. m.	7 oz. milk and cream
8:30 a. m.	Well cooked cereal with sugar and cream 1 spoon applesauce 1 poached egg on toast Glass milk and cream
11:00 a. m.	Glass milk and cream
12:30 p. m.	Very tender meat or fish Baked or mashed potato with butter; toast Tapioca pudding with cream Glass milk and cream
3:00 p. m.	Glass milk and cream
5:00 p. m.	Glass milk and cream Toast with butter and preserves
6:30 p. m.	Soft boiled egg, cream of wheat with butter 2 slices toast Rice pudding (no raisins) with cream Glass milk and cream
9:00 p. m.	1 glass milk and cream, orange Jello with cream or small, well baked apple without core or skin.

REFERENCE
Pattee's Dietetics, Mt. Vernon, N. Y. 1933

Diet 4:

STANDARD BLAND DIET

Breakfast:
- Eggs, boiled or poached
- Cereal
- Milk
- Bread or toast and butter
- Coffee, if allowed

Lunch and Dinner:
- Meat: Broiled steak, roast beef, lamb, mutton or chicken (broiled, boiled or roast)
- Fish: Baked, broiled or boiled
- Vegetables: Potatoes, peas, squash, cauliflower, asparagus tips (well cooked or mashed)
- Later: Carrots, beets, beans, spinach, macaroni
- Bread or toast and butter
- Desserts: Gelatine jelly (Jello). Tapioca, rice, stale bread, or cornstarch pudding. Custard, ice cream, stewed prunes, canned peaches, pears, plums, baked apple, apple sauce, sponge cake
- Drinks: Milk, buttermilk, cocoa, water, tea if allowed

Avoid:
- Everything fried or fat
- Everything highly spiced or seasoned. All mustard, vinegar, ketchup, horseradish, relishes, sauces and gravies
- All tinned, smoked and preserved meat and fish
- All pork, veal and game
- All raw fruit
- All stimulants, tea (unless allowed), coffee (unless allowed) and carbonated waters
- All pastries, preserves and candies

Reference: Treatment of the Common Disorders of Digestion, John L. Kantor, M.D., C. V. Mosby Co., St. Louis, 1924.

956 E. Jersey St.

EARLY TREATMENT OF HAY-FEVER IN INFANCY

Jules London, M.D., Passaic, N. J.

I am making a report of this case of hay-fever because hay-fever under one year of age is rare and therefore of interest.

A white boy four months old was referred to me on August 24, 1942, by Dr. L. Spicola of Lodi, New Jersey, for treatment of his hay-fever. He presented the common symptoms of nasal congestion and blocking, fits of sneezing, mucoid discharge from eyes and nose, and itching and redness of the eyes. The nasal mucous membrane was pale and swollen.

A smear of the nasal discharge stained with Giemsa Stain showed several eosinophils. A blood smear showed four per cent eosinophils.

Scratch tests made on the skin of the back with powdered extracts showed positive reactions to—

Ragweed Short
Ragweed Giant
Cocklebur

Treatment was instituted with a mixture of equal parts of Ragweed Short and Ragweed Giant, 1-50,000 dilution given subcutaneously at intervals of three to five days. Beginning with 0.03 cc. first dose and gradually increasing to 0.12 cc. on October 3, 1942, when the last treatment was given.

Symptoms were greatly alleviated within a few days of the first treatment and the boy reacted well through the hay-fever season of 1942.

There has been no recurrence of his hay-fever since 1942.

This case suggests the possibility that early institution of hay-fever treatment during the first season of its occurrence may result in a rapid cure.

EVERY GOOD OBSTETRICIAN WITH INsight into the deeper motivations of his patients is intuitively a mental hygienist. If he is aware of the latest findings of mental hygiene, he can use these to supplement his own intuition.—M. E. Freis, M.D., in "Mental Hygiene in Pregnancy."

♠ ♠ ♠

"WITHOUT CO-OPERATION OF THE PEOPLE a doctor can no more prevent tuberculosis than he can prevent accidental drowning."—U. S. Pub. Health Serv. Rep.

DETECTIVE STORY WRITERS LIKE TO thrill readers with gruesome stories of the growth of hair and nails after death. Beards appear on the face of the freshly-shaven corpse, and bodies exhumed from the grave are alleged to have grown sharper, longer nails. All that happens is that the shrinkage of skin permits small stubbles of hair to appear, and allows the nails to protrude a little more than at the time of death. No scientific evidence supports the canard that any part of the body can grow or function after general body death.

THE DIFFERENTIAL DIAGNOSIS OF SULFA DRUG REACTIONS

H. C. Goldberg, M.D., Plainfield, N. J.
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The value of sulfa medication is clearly shown by its extensive use. The extent of its use is evidenced by the fact that 4,514,500 pounds of sulfa drug preparations were manufactured in 1944.[1] By way of comparison, 9,423,400 pounds of acetyl salicylic acid were manufactured in the same year.[1] Although specific indications for the use of a drug is a therapeutic ideal, in practice many acute, sub-acute and chronic illnesses are eventually treated with sulfa medication. It is thus obvious that a large percentage of the population is or has been treated with these drugs. A poll[2] of 200 persons showed that 35 per cent had taken sulfa medication. These persons were patients in my practice who were not receiving sulfa medication from me. They were questioned as to whether or not they had or were taking a sulfa drug. And remember that despite these high figures, these drugs may be obtained in the state of New Jersey, only in drug stores on prescription orders from Doctors of Medicine.

A pharmacologic and toxicologic explanation for the drug reactions occurring in sulfa therapy is given by Ernest P. Pick. "The most commonly used sulfa drugs are the products of the substitution of hydrogen in the sulfamido group, by thiazole (sulfathiazole), by pyrinidine (sulfadiazine), by pyridine (sulfapyridine), by quanidine (sulfaquanidine), etc. These formulae then appear as follows in Illustration No. 2.* The desired pharmacologic effects of the sulfa drugs depend on a satisfactory concentration of the free drug in the body. The sulfa drugs are conjugated in the liver with an acetyl or with a glycuronic group. These products are eliminated with difficulty by the kidneys which accounts for many of the genito-urinary symptoms."[3]

The chief toxic effects may be divided into five groups. First, the effects upon the central nervous system. These are chiefly anorexia, nausea, and vomiting. Large doses of sulfonamids cause convulsions and spasticity in animals. It is now a familiar fact that ambulatory patients taking sulfonamids may show a slowed reaction time, thus making it necessary that special care should be observed by these persons in performing their duties, as driving a car, or performing manual work. In this connection, it must be further pointed out that preliminary treatment with sulfa drugs leads to a considerable increase in the toxicity of papaverine, codeine, morphine, barbiturates, and novocaine-adrenalin mixtures.

A second and common reaction is "drug-fever". The mechanism of this phenomenon is at present not understood. It may occur without any other drug-reaction symptom or sign.

Thirdly, all sulfonamids may produce blood disorders of almost any type. No permanent damage usually results if drug therapy is discontinued early. The anemias produced tend to recur frequently on re-administration of the drug. Sulfapyridine seems to be the drug most often responsible for producing an agranulocytosis.[3]

A fourth toxic reaction is visceral damage. Liver damage may produce a fatal result. The pathology in such cases is similar to that found in acute yellow atrophy. The types of kidney damage may be due to precipitation of acetylated sulfo-compounds, or to a true toxic nephritis. Renal damage is of rare occurrence with sulfanilamid therapy.

A fifth drug reaction is the skin manifestations with or without fever, lymphadenopathy, splenomegaly and arthralgia. Photo-sensitization may develop. One type of psoriasis therapy is based on this fact, and consisted of deliberate exposure of the patient to ultra-violet therapy following administration of sulfanilamid.[4] This treatment showed poor results.

The earliest reports of sulfa drug toxicity were published on various types of reactions occurring with sulfanilamid therapy. These reactions included a varioform eruption, a bullous eruption, the phenomenon of photo-sensitization, dermatitis medicamentosa, exfoliative

* See page 90 this issue.

dermatitis, and porphyrinuria.[5a, b, c] The earliest reports of sulfathiazole eruptions, according to the Year Books of Dermatology and Syphilology occurred in 1940. In that year, the first article was reviewed on the cutaneous, conjunctival and scleral reactions which occurred in the course of therapy with sulfathiazole.[6]

In 1941,[7] several reactions were reported due to sulfanilamid, including a pemphigus foliaceus-like eruption after sulfanilamid and sulfapyridine. A report was reviewed on sulfanilamid cyanosis, on sulfanilamid psychosis, and a sulfanilamid fixed drug eruption. One case was reviewed of an "allergic arthritis" occurring during the use of sulfathiazole in the treatment of chancroid.

In 1942 [8] many more case reports began to appear with reactions varying from photosensitization and angio-neurotic edema, to erythema multiforme.

In 1943, an article reported the following toxic reactions which had been observed during therapy with the sulfa drugs. These include drug fever, dermatitis, conjunctivitis or episcleritis, mental confusion, hematologic complications, vomiting, renal calculi, oliguria, anuria, and hematuria.[9] An intradermal test for the recognition of hypersensitivity was worked out and described by Liftwich.[10] This has not found practical application. An important point is emphasized by R. G. Park, that sensitization can occur due to topical sulfonamid therapy.[11a] This is also emphasized by Shaffer et al.[11b]

A careful report on 196 patients treated at Bellevue Hospital with sulfathiazole, showed that 14 per cent developed a fever, 10 per cent a drug eruption, 5 per cent a conjunctivitis, 1.5 per cent a leukopenia, 10 per cent a headache, 6 per cent nausea, 4 per cent vomiting, 1.5 per cent psychic disorientation, 1.5 per cent chills, .5 per cent jaundice, .5 per cent hepatitis, 1 per cent arthalgia, .5 per cent neuritis.[12]

The value taken from the above paper of a 10 per cent occurrence of skin eruptions in patients treated with sulfathiazole is substantially correct. It is clear, then, that a physician treating as little as one patient a week with this drug may expect to have five patients a year in his own practice, who have a sulfa drug eruption, the total number of sulfa drug reactions being substantially higher. This conservative estimate, therefore, calculated on the basis of 100,000 practicing physicians, gives an approximate minimum figure of one half million cases of sulfa drug eruptions occurring in the United States each year.

In the 1944 Year Book of Dermatology and Syphilology, the reports reviewed continue to be more numerous and now repetitious in character. The types of toxic reactions are now well worked out, are observed in large numbers and may be readily and completely described.

The average mild toxic reaction in an individual usually follows the course of case No. 1.

B. W., a white male machinist, age 25, developed a series of boils. In addition to other therapy, sulfathiazole tablets, gr. vii ss were prescribed to be taken two at one time every four hours. The patient developed mild nausea and headache on the ninth day of this drug therapy. He continued with the tablets. On the eleventh day, he was examined in the office. He stated he had noticed generalized itching. On this same day, irregular blotchy purpuric patches had developed on the front of his legs. A few hives were also noticed at this time, scattered over the body. He had an oral temperature of 99° F. He was told to stop taking the sulfathiazole tablets, which he did.

On the twelfth day, the patient had a full-blown urticaria, with large and confluent hives, which covered large areas of the body and especially the face. Present in addition to the hives, were numerous bright red macules. Considerable swelling of the hands was observed. The oral temperature was 100.5° F. Therapy at this time was now limited to overcoming the drug reaction. This consisted of bedrest, forcing fluids, and an anti-pruritic lotion. On the fifteenth day after starting this drug, and the sixth day following the beginning of the sulfa drug reaction, all symptoms had practically disappeared. It is interesting to note the long incubation period present before the drug reaction occurred. This is usually found when the drug has been taken for the first time, although the average period is shorter. On re-administration of the drug the time of onset of the reaction is usually considerably shortened.

The photograph represents a more severe reaction, which occurred in J. M., case No. 2, a patient who was under my care in a naval hospital. He had self-administered sulfathiazole tablets, and had continued to take them after toxic symptoms occurred until forced to report for medical care by the severity of his symptoms. The signs and symptoms were similar to and illustrate those of case No. 1, but to a much more marked degree.

The purpuric areas about the upper chest and shoulders, and groin were well marked. A bullous

eruption was present on the left lower ankle. Considerable swelling of the penis and scrotum is clearly discernable. The patient's toxic condition is evidenced by the need for support by the pharmacist's mate while the photograph was being taken. In contrast to case No. 1, B. W., who had practically completely recovered from all ill effects of the sulfa drug in six days, this patient required over two months of hospitalization before being restored to active duty. His treatment consisted of stopping of the sulfa drug, and symptomatic care.

Case No. 3, H. G. R., a white male, age 43, was hospitalized because of an extensive dermatophytosis of the feet with fissuring of the toes, and an acute lymphangitis of both legs. He was treated for the latter condition with sulfadiazine, gr. vii ss, two tablets every four hours. On the third day of the administration of this drug, a severe generalized swelling and pain of the joints occurred, especially in the wrists and knees. These symptoms and signs cleared within several days after this medication was stopped. This patient's wife had had a similar arthritic involvement following the use of sulfadiazine on a previous occasion.

Case No. 4, H. G., was given sulfathiazole in the usual dosage, for a cellulitis of the hand. Intense headache developed after three doses of this sulfa drug were given and the drug was discontinued. A blood count on the following morning showed a normal red count, but a total white count of only 3,000 with 54 per cent polymorphonuclear leucocytes, 41 per cent lymphocytes, 3 per cent monocytes, and 2 per cent eosinophils. On successive days the total white count was 4,250, then 4,700. One week after stopping the drug, the total white count had risen to 7,500. On the second day after the drug was stopped, a few hives were present, and marked itching and inflammation of the conjunctivae had occurred. The hives and the conjunctivitis cleared within two days after they were first noticed.



ILLUSTRATION No. 1
A Sulfa Drug Eruption. Case No. 2.

The other sulfa drugs may vary in their toxic reactions, but in general follow the signs and symptoms mentioned as occurring in the cases cited, and in the literature reviewed.

There is a definite tendency for some of the different sulfa drugs to cause more particular types of toxic reactions, although any of them can cause any type of toxic reaction. Of the two most commonly used drugs, sulfathiazole produces numerous mild toxic reactions, especially headache, and skin eruptions. Sulfadiazine frequently causes swelling and pain in the joints.

The diagnosis of a sulfa drug reaction may be summarized as the occurrence of any or all of the numerous toxic manifestations mentioned, during or following sulfa drug medication. These vary from slight to severe nausea, vomiting, diarrhea, dizziness, headache, conjunctivitis, and urticaria. Macular, papular, nodular, and bullous eruptions, and photosensitization phenomena may develop. Hematologic, genito-urinary, and arthritic effects are frequent. Visceral and nervous system involvement also occur.

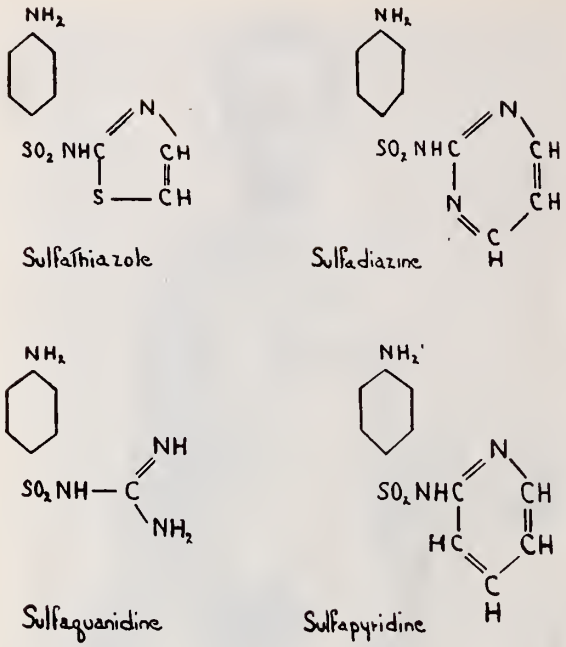


ILLUSTRATION No. 2

Formulae of Several Sulfa Drugs.

Laboratory confirmation in establishing the diagnosis is chiefly of value, when identification of the presence of a sulfa drug in the body is necessary. This would be desirable in a few cases, when a careful history cannot be obtained concerning the patient, and the diagnosis of a sulfa drug reaction is being considered.

The use of a sensitization test [10] as a prophylactic measure or for diagnosis is not practicable. The most important point in the diagnosis of a sulfa drug reaction is to know or suspect that a sulfa drug is or has been taken by the patient, in the presence of signs and symptoms attributable to these drugs. The physician may also be called to treat these drug reactions, without being given a history of the sulfa administration, or even with a denial of this, when it is suggested by the physician.

Despite the above simple cause and effect mechanism in producing sulfa drug reactions, the differential diagnosis of diseases simulated by these reactions is important. Syphilis has been called the great imitator, and so too, can the sulfa drug reactions be called.

Innumerable diagnoses can and have been confused with these sulfa drug reactions. Three cases will be given to illustrate.

Case No. A-5. The most frequent condition which may be confused with the sulfa drug eruptions is a different drug eruption. Mrs. P. Y. developed a large edematous and indurated purple red plaque over her left scapula. This had occurred on previous occasions. She was receiving one sulfathiazole tablet gr. vii ss two times a day for a chronic acne varioliformis. She also took a phenolphthalein laxative. The phenolphthalein drugs often produce such fixed drug eruptions. Stopping the use of the laxative failed to bring about improvement. Changing from the sulfathiazole tablets to sulfadiazine tablets produced a gradual and complete clearing of the involved skin area. This was considered sufficient evidence indicating that the condition was a "fixed" sulfathiazole eruption.

Case No. B-6. Mrs. F., white, age 54, had been hospitalized for a severe bronchitis and fever. Sulfa medication had been given prior to and continued following hospitalization. Because of a fine macular eruption on the abdomen and the fever, a tentative diagnosis of typhoid fever was considered. Blood tests for typhoid fever were negative. The diagnosis of a sulfa drug reaction, with drug fever, and a macular skin eruption was suggested. All symptoms cleared rapidly with cessation of the sulfa medication.

Case No. C-7. Mrs. K., a patient with a thrombophlebitis of the leg, was treated at home with sulfa tablets. Her condition became progressively worse with development of a skin eruption. She was hospitalized with a tentative diagnosis of a thrombophlebitis, together with erysipelas and a pyoderma. The sulfa medication was continued after hospitalization. Penicillin was given in addition. The condition of the patient became steadily worse. A later diagnosis of a thrombo-phlebitis of the leg and an erythema multiforme eruption was made. This toxic eruption was considered most probably due to the sulfa medication. The patient when seen at this time was moribund. Cessation of the sulfa drug resulted within twenty-four hours in a marked drop in the patient's temperature and some improvement of the sensorium. She died suddenly two days later.

To summarize, the variety of diseases simulated by the sulfa drug reactions is endless, and offers a serious problem in diagnosis. It has been shown that the use of sulfa drug preparations is enormous. The benefits of these drugs are specific and most helpful. Their disadvantages are small, but definite drug reactions occur. It its with this latter characteristic and its details that this article has dealt. It is essential that the physician be drug-minded

for these sulfa reactions, especially when he is himself prescribing a sulfa drug.

Stop the sulfa drug if symptoms, suggestive or definite of a sulfa drug reaction appear. It is usually feasible to simply switch to a different sulfa drug than the one used. If a severe reaction has occurred, it would be safer not to use any sulfa drug and use penicillin. Penicillin can readily be substituted in hospitalized cases and can also be used in home cases. It often provides the means to continue good and specific therapy without the use of any sulfa drug. Lastly, the thought of a possible sulfa drug reaction can check early sulfa drug reactions and prevent the more severe effects of such reactions.

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MUSCLE SPASM IN POLIOMYELITIS

Substantiation of the concept of the Australian nurse, Miss Elizabeth Kenny, that muscle spasm "is a damaging and ever present symptom of the disease infantile paralysis * * *" is reported in the July 18 issue of *The Journal of the American Medical Association* by R. Plato Schwartz, M.D., and Harry D. Bouman, M.D., of the University of Rochester School of Medicine and Dentistry, Rochester, N. Y.

By making graphic records of the electric current produced by muscles in action, the two investigators found that spasm exists not only in the muscle opposite (antagonist) the muscle weakened by infantile paralysis, as contended by Miss Kenny, but it also exists in the weakened muscle itself and in muscles in parts of the body in which clinical symptoms of the disease are not evident.

The term "muscle spasm" denotes a group of symptoms including twitchings, excessive irritability of the muscle to stretching and a more or less continuous state of contraction of the muscle fibers.

Drs. Schwartz and Bouman explain that the recent increase in favorable observations regarding the Kenny concept of spasm in the acute stage of infantile paralysis has not been accompanied by evidence from any investigation aimed specifically at verifying this concept. Accordingly, they say, "it was necessary to approach this question of muscle spasm by a method which would be independent of, but could be correlated with, clinical observations.

"Action currents are among the means most suitable for recording extremely minor contractions of muscle. * * * The rigid principles that define the technic of this method were applied to the study of patients: (1) seven with infantile paralysis, (2) three with spastic paralysis and (3) normal subjects for control. * * *"

Other conclusions reported by the two investigators are as follows:

"The spasticity is of a reflex nature and is not present in the completely paralyzed muscle.

"The spasticity can be stronger than the voluntary contraction that the muscle is able to perform, as adjudged by action currents.

"When the strength of the voluntary contraction increases through treatment, the spasticity decreases.

"Our investigation has shown that spasticity is present in infantile paralysis. Whether the spasticity is actually responsible for weakening of the muscle or whether it is a phenomenon which is merely another consequence of the disease is a question which cannot be answered at the present time."

CHEMOTHERAPY IN MANAGEMENT OF LEUKORRHEAS

ANNE HOROSCHAK, B.S., M.D.; STEVEN HOROSCHAK, B.S., Plainfield, N. J.

This is an analysis of the treatment of leukorrhea in 53 patients. Observed etiologic factors in this series were: (a) Nonspecific infections in 19 cases; (b) trichomonas infestation in 16; (c) cervical erosion in 9; (d) endocervicitis, mixed infection, in 8; and (e) one patient with a perineal abscess.

NONSPECIFIC INFECTION

In this category are placed cases in which there was no notable localized infection of Skene's ducts, and where no gross deformities, lesions of the cervix, trichomonads or monilia were present.

Causative factors of *non-specific infections* are: hyperplastic cervical glands after termination of pregnancy are most prevalent in producing non-specific leukorrhea; abortions, spontaneous or instrumental, particularly the latter, are definite factors. Leukorrhea occurring in young women may be ovulatory in origin. Discharge in these patients occurs between menses usually as a mucoid secretion free of bacteria. At menopause, a deficiency in estrogenic hormone may result in leukorrhea. Traumatism from too frequent douching, coitus, or as a result of foreign bodies, is a contributing factor in many cases.

Most frequent complaint is a discharge producing an irritation. They complain also of vaginal burning, marked tenderness and dyspareunia. Lesions observed in this type of leukorrhea include excoriations, mottled red spots and shrinkage of the membranes.

TRICHOMONAS

Trichomonas vaginalis vaginitis is either becoming more prevalent, or the diagnosis of this condition is being made more frequently as a result of more careful laboratory procedure in identifying trichomonads. This flagellate is responsible for low-grade inflammatory conditions, which may provide a favorable condition for the trichomonads, as secondary invaders, thus aggravating a pre-existing condition.

The patient invariably complains of itching, burning and a discharge, with signs of vaginal inflammation. The discharge, exuding from the introitus, has an offensive odor, and is frothy, seropurulent, creamy, yellowish and acid.

The vaginal walls are injected, tender and show hyperemia and pectechial hemorrhages. In more advanced cases, granular areas may be observed. The surface is usually covered in places with coagulated material containing trichomonads, leukocytes and red blood cells. The vaginal and cervical mucosa is highly injected with a bright or dark red punctate mottling producing the so-called "scarlet fever" or "strawberry" vagina, which is pathognomonic. These conditions appear to be of toxic or bacterial origin and not primarily due to the invasion by trichomonads.

CERVICAL EROSION

This is characterized by a red granular area surrounding the external os, due to maceration and desquamation of the squamous epithelium, and the covering of the denuded areas by cylindric ciliated epithelium which grows from the cervical canal. The cervical discharge is usually stringy, tenacious and mucoid, but may at times be mucopurulent. Causes include cervical laceration, cervicitis, endometrial discharge or a congenital anomaly.

ENDOCERVICITIS

Endocervicitis results most frequently from trauma of the cervix. This permits the introduction of the mixed bacterial flora made up of anerobic streptococci, colon bacillus and diplococci, into the racemose glands, thus occluding them. In this way, the glands are converted into retention cysts, known as *Nabothian follicles*. The endocervix appears dark red, presenting a granular appearance and small cysts. Exuding from the cervix is a yellow or greenish-yellow mucus discharge. In addition to the pyogenic organisms found in this discharge, leukocytes and fibrin are present, rendering it opaque.

MANAGEMENT OF LEUKORRHEAS

The introduction of the sulfonamids has created a false sense of security in the prophylaxis and treatment of many conditions. This has resulted in the promiscuous use of the sulfonamids in conditions where they could do no possible good. Unless the sulfonamid can come into intimate contact with the bacteria, its therapeutic value is considerably reduced.

As pointed out by McClintock[1]: "The efficacy in the topical use of sulfonamids in bacteriostasis has been found to be directly proportional to three factors: concentration of the sulfonamid inhibitors, solubility and diffusibility of the drugs, and degree of active cellular defense within the wound."

Though the presence of allantoin or other agents in the wound may aid in the elimination of the infection by making possible a higher concentration of the sulfonamid and by their action on necrotic cellular proteins and pus, it is, nevertheless, strongly stressed that the latter should be removed by mechanical means before topical chemotherapy of any type is instituted. The action of sulfonamid inhibitor agents can be neutralized by allantoin, a terminal oxidation product of purine metabolism. Tremble [2] and Saralegui and Villaneuva [3] found that allantoin-sulfonamid mixtures accelerate the elimination of substances which inhibit sulfonamid action and healing, stimulate cell proliferation by the synergistic action of the two components. Parks [4] recommended allantoin-sulfanilamid-lactose in a special greaseless base as a convenient and effective method of treating many ulcerative lesions of the lower genital tract. Smith [5] reported the successful treatment of non-specific infections of the vaginal tract with the cream suggested by Parks.[4]

PROCEDURE

Non-Specific Infections (19 Patients): The etiologic factors found in this group of patients were varied, and included the following: leukorrhea developed in three patients following pregnancy; in three following spontaneous abortion and in two as a result of instrumental abortion. Two were of ovulatory origin; 4 menopausal and 2 patients with senile vaginitis. Two were of traumatic origin; one due to excessive coitus and the other to frequent ice water douches. One patient presented a severe perenial laceration.

To be considered in the therapy of non-specific vaginitis are the avoidance of predisposing factors, hygienic measures without traumatism and, a most important factor, the general health of the patient.

Allantoin 2 per cent—sulfanilamid 15 per cent—lactose 5 per cent—in a special greaseless base buffered to an acid pH * was prescribed for all the patients in this group. In patients with ovulatory leukorrhea, the pruritis was definitely controlled within three days, with two applications of the cream each day. This was supplemented by oral administration of thyroid and control of diet. No other therapy was given. Patients with menopausal leukorrhea and senile vaginitis received the necessary endocrine therapy in addition to the cream, which was applied for three days only. The endocrine treatment was sufficient to control their leukorrhea symptoms thereafter.

The remaining patients had excoriations and mottling of the mucosa. Initial step in treatment of these patients was a cleansing vinegar douche followed by insertion of the allantoin-sulfanilamid-lactose cream twice daily until the lesions were healed. In all patients the discharge became less in two days and healing was complete in an average of four weeks.

Trichomonas Vaginalis Vaginitis (16 patients): As has been pointed out by Hesselstine, et al.,[6] trichomoniasis is unlikely in the presence of a normal bacterial flora. The return of the normal flora may be hastened by the use of ordinary vinegar (one tablespoonful to two quarts of water) douches as recommended by Karnaky.[7] Successful management of trichomonas infestation with a cream containing allantoin 2 per cent—sulfanilamid 15 per cent—lactose 5 per cent buffered to an acid

1. McClintock, L. A., and Goodale, R. H.: Improvement of Wound Therapy by Synergistic Mixtures of Antibacterial Substances. U. S. Naval M. Bull. 41: 1057 (July) 1943.
2. Tremble, G. E.: Conservative Treatment of Sinusitis. Canad. Med. Assoc. Jr. 49: 496 (Dec.) 1943.
3. Saralegui, F. A., and Villaneuva, A. A.: Local Sulfonamid Therapy and Repair of Tissues. Revista de la asoc. Med. Argentine, Buenos Aires, 58: 547 (July) 1944.
4. Parks, J.: Treatment of Infections of the Cervix and Vulva with allantoin-sulfanilamid-lactose ointment. Med. Annals of Dist. of Col. 12: 175 (May) 1943.
5. Smith, J. G.: Treatment of Non-Specific Infections of Vaginal Tract. West Va. Med. Jr. 41: 75 (March) 1945.

* Supplied through courtesy of National Drug Company, Philadelphia, Pa.

pH was reported by Parks.[4] It was observed by Roblee [8] that "controlling the vaginal pH at 4.0-4.5 by the addition of buffered jellies is of value in the management of cervicitis and vaginitis, especially the trichomonas type of vaginitis."

After the diagnosis of Trichomonas vaginalis vaginitis had been established clinically and bacteriologically, the cervix, vagina and external genitalia were thoroughly exposed and cleansed with about two quarts of an aqueous solution of phenyl mercuric nitrate (1-12,000). The entire vaginal tract was then dried thoroughly with soft cotton pledgets, and one applicator of the allantoin-sulfanilamid-lactose cream was inserted into the vagina. The patient was instructed to use the cream morning and night with an ordinary vinegar douche (one tablespoonful of vinegar to two quarts of water) preceding the morning application. All patients became symptom-free and bacteriologically negative from three days to four weeks with an average of two weeks after treatment was started. As a prophylactic measure, the patients were instructed to continue the use of the allantoin-sulfanilamid-lactose cream with two applications weekly, preceding the treatment with a cleansing vinegar douche. After a seven months' follow-up, only one patient showed an apparent recurrence.

Erosion of Cervix (9 Patients): Many erosions, unless they produce a discharge that proves annoying to the patient, require no treatment. Consideration should also be given the fact that successful treatment of cervicitis (which in many cases is a predisposing factor) will result in healing of the erosion.

In the patients presented in this group, local treatment of the cervical erosion was deemed necessary. Treatment consisted of cauterization of the involved areas, and application of the allantoin-sulfanilamid-lactose cream twice daily. Healing time was reduced on the average of one-half compared to previous accepted methods of treatment. The pain was usually controlled and the patients commented on the comfort afforded them by use of the cream.

Endocervicitis (Mixed Infection—8 Patients): It is doubtful whether sulfonamids applied topically in the treatment of this type of leukorrhea would be effective, since it is known that pus, necrotic tissue, and seropurulent media inhibit the bacteriostatic action of these drugs. Removal of these antagonists by mechanical or chemical debridement is essential for successful local sulfonamid therapy.

In the patients in this series all local treatment was preceded by thorough cleansing of the vagina and vulva, then by application of the allantoin-sulfanilamid-lactose cream with an applicator twice daily, morning and night. The discharge became modified and altered in its physical characteristics after the third or fourth application. Six of the eight patients were clinically and bacteriologically (as indicated by vaginal smears and cultures) cured within two weeks of treatment. The two patients still showing evidence of infection were continued on treatment for an additional two weeks, after which they were apparently cured.

SUMMARY

Leukorrheas resulting from the various etiologic factors were successfully treated with allantoin 2 per cent—sulfanilamid 15 per cent—lactose 5 per cent in a special greaseless cream base buffered to an acid pH.

Trichomonas vaginalis vaginitis in 16 patients was cured by the described treatment. After a seven months' follow-up, only one patient had a recurrence.

The allantoin-sulfanilamid-lactose cream has proved to be the most effective treatment of endocervicitis (mixed infection) we have found for this condition.

Erosions of the cervix treated with the cream after cauterization healed in about half the usual time necessary for the usual treatment.

In non-specific infections of the lower genital tract in the female, the allantoin-sulfanilamid-lactose cream as a supplement to essential therapy, such as endocrine, thyroid and diet, neutralized the pruritis and hastened the healing of excoriations.

974 Park Avenue

6. Hesselstine, H. C.; Walters, S. L., and Campbell, A.: Experimental Human Vaginal Trichomoniasis. Jr. Infec. Dis. 71: 127 (Sept.) 1942.
7. Karnaky, K. J.: Normal Physiologic Douches. South. Med. Jr. 30: 69 (Jan.) 1937.
8. Roblee, M. A.: Local Use of Acid Media and Sulfa Drugs in Cervicitis and Vaginitis. Amer. Jr. Ob. & Gyn. 46: 400 (Sept.) 1943.

DERMATITIS VENENATA OF THE EYES AND EYELIDS FROM THE LOCAL USE OF PENICILLIN *

E. M. SATULSKY, Major, M.C., A. U. S.

The various reactions from penicillin reported in the literature have been attributed to the drug itself, contaminants, or toxic impurities. A review of these reports will reveal multiform reactions following the systemic administration of this drug and from direct contact with it. These include urticaria, gastrointestinal reactions, chills, fever, headaches and faintness, vesicular and bullous dermatitis and pruritus. Other reports have recorded sensitization and allergic reactions simulating serum sickness and severe asthma.[1, 2]

My experiences at Gorgas Hospital with penicillin have thus far been uneventful except for an occasional case of mild urticaria and fever. It is my purpose in reporting the following case to describe a true allergic hypersensitivity caused by the local use of penicillin.

CASE REPORT

A 31-year-old insular soldier was transferred to Gorgas Hospital on 30 April 1945 with the following diagnosis: "Keratitis, ulcerative, chronic, severe, right eye." Various studies were done to rule out all possible foci of infection. Cultures from the conjunctival sacs were negative. On 2 May 1945, after an adrenalin series, thick and thin smears of the blood were positive for tertian malaria parasites. He was immediately started on treatment with atabrine. The Eye Service instituted local treatment for the affected eye. On 3 May 1945, penicillin ointment was instilled in the right eye. The formula for this ointment is as follows:

Penicillin sodium	100,000 Oxford Units
Liquid petrolatum	15.0 grams
Petrolatum alba	35.0 grams
Adeps lanae (anhydrous)	50.0 grams

(1,000 Oxford Units of penicillin per gram.)

In several hours he began to complain of severe burning and pain in the right eye associated with lacrimation and photophobia. A severe conjunctivitis developed shortly thereafter which was associated with erythema and edema of the eyelids and adjacent skin of the nose and cheek. The ointment was immediately discontinued and the conjunctivitis and dermatitis cleared up in several days under bland treatment.

After the acute symptoms had subsided, he was patch-tested:

	48 Hours	72 Hours
1. Penicillin ointment	+++ (erythemato-vesicular)	+++
2. Penicillin solution (1 c.c. containing 5,000 Oxford Units in isotonic sodium chloride solution.)	+	+
3. Liquid petrolatum	—	—
4. Petrolatum alba	—	—
5. Adeps lanae anhydrous	—	—
6. Crystalline penicil'in	++	+

On 13 May 1945, penicillin solution (1 c.c. containing 5,000 Oxford Units in isotonic sodium chloride solution) was instilled in the right eye. Within one hour he complained of severe burning, itching and lacrimation. The conjunctiva was acutely inflamed and the skin of the lids and malar area was erythematous. The inner and outer canthus of the eye and the side of the nose where the solution had trickled were acutely inflamed and edematous. This acute episode also subsided in several days under bland treatment.

There were no signs of urticaria and no fever. He gave no history of eczema or of sensitization to any other substance. Examination failed to reveal any clinical signs of a fungus infection. It is interesting to note the concomitant effect of the penicillin on the conjunctiva and the skin of the lids and the cheek. The difference in the patch test results was apparently caused by the macerative action of the ointment base.

Keyes [3] has described a case of dermatitis venenata of the eyelids caused by the instillation of penicillin solution into the conjunctival sac. His patient gave a history of sensitivity to a number of substances. The cases reported by Binkley and Brockmole [4] and Silvers [5] were of dermatitis of other parts of the body associated with involvement of the lids. Selinger [6] reports a case of dermatitis of the lids with an

* From the Department of Dermatology, Medical Service, Gorgas Hospital, Ancon, Canal Zone.

1. Criep, L. H.: Allergy to Penicillin. J. A. M. A., 126: 429 (Oct. 14) 1944.
2. Price, D. E., et al.: Severe Asthma: Delayed Sensitization to Penicillin. J. A. M. A., 128:183 (May 19) 1945.
3. Keyes, J. E. L.: Penicillin in Ophthalmology. J. A. M. A., 126:610 (Nov. 4) 1944.
4. Binkly, G. W., and Brockmole, A.: Dermatitis from Penicillin: Report of 2 cases. Arch. Derm. & Syph., 50:326 (Nov.) 1944.
5. Silvers, S. H.: Contact Dermatitis from Amorphous Penicillin. Arch. Derm. & Syph., 50:328 (Nov.) 1944.
6. Selinger, Elias: Dermatitis of the Lids from Penicillin Eyedrops. J. A. M. A., 128:437 (June 9) 1945.

absence of conjunctival irritation caused by the use of penicillin eyedrops. Pyle and Rattner [7] reported cases of blepharitis and conjunctivitis in handlers of this drug. Barker [8] has also reported a case of blepharitis and eyelid involvement in a handler of the drug.

I have used penicillin incorporated in various bases for several dermatologic conditions and have seen no untoward reactions. The clinical uses of this drug in external ocular diseases are encouraging and should be continued in suitable cases.

737 North Broad Street, Elizabeth, N. J.

SPINAL ANESTHESIA BY URETERAL CATHETER

At present the catheter technic, as compared with the use of the malleable needle, has been attended by fewer mechanical difficulties in my experience. There have been no situations in which the catheter has inadvertently slipped out of the subarachnoid space. It has been my opinion that the catheter causes less trauma to the soft tissues than does a needle over a protracted period of time.

The failure to insert the ureteral catheter easily in some cases has been found to be due to the fact that the 15 gage needle was advanced too far intrathecally and insufficient space was remaining between the point of the needle and the body of the vertebrae to allow the catheter to pass. If the needle is withdrawn slightly, with an effort meanwhile to advance the catheter, entrance of the catheter into the subarachnoid space will be accomplished. One precaution must be exercised; namely, that the catheter should not be withdrawn through the needle once the catheter has entered the subarachnoid space, because the sharp point and bevel of the needle may shear off the catheter. If the catheter must be removed or partially withdrawn for any reason during the procedure, the needle should be withdrawn first from the lumbar interspace. The direction (cephalad or caudad) which the catheter will advance in the subarachnoid space after the tip of the catheter leaves the end of the guiding needle cannot be predicted positively; however, if the round tip of the catheter is bent slightly before it is introduced into the lumen of the needle, I have found that the catheter will advance cephalad in most cases. This has been verified radiographically by using the leaded ureteral catheters. In the event that the catheter turns caudad on entering the subarachnoid space, this fact can usually be detected shortly after the initial dose of the spinal anesthetic has been introduced because of the segmental distribution of the resulting anesthesia. When this situation occurs it is suggested that the remaining amount of the anesthetic solution in the syringe be diluted with an equal volume of isotonic solution of sodium chloride, and twice as much solution (volume) should be administered in order to produce higher dermatome anesthesia. Barbotage is not recommended, but it can be accomplished via the catheter if it is deemed necessary.

This procedure (ureteral catheter technic) has been taught to student officers in training in anesthesiology and I think the technic cannot be too difficult, as they can successfully use the equipment without perceptible difficulty in a relatively short time. I know that some other anesthetists are using this method, and it appears to be satisfactory also in their experience. The challenge that the 15 gage needle is unnecessarily traumatic for subarachnoid puncture is accepted, but in retaliation I offer the data that up to the present time no untoward effects have resulted from the use of this 15 gage needle, and it has been just as easy to insert this needle as it has been the malleable needle used with the Lemmon procedure. It has appeared to me that the efficient operation of the catheter system is an improvement in achieving the fundamental principles of continuous spinal anesthesia as originally suggested by Lemmon. Naturally it will be necessary to have further experience with a larger series of cases to have a complete evaluation of this method, but I think that it is worthy of trial and is to be recommended as an adjunct to this type of anesthesia. The total cost of this equipment is relatively small as compared with the equipment necessary with other methods of continuous spinal anesthesia. This may or may not be an important factor.—puncture is accepted, but in retaliation I offer Major Edward B. Tuohy, J. A. M. A., Vol. 128, No. 4, p. 262.

7. Pyle, H. D., and Rattner, H.: Contact Dermatitis from Penicillin. J. A. M. A., 125:13 (July 29) 1944.
8. Barker, A. N.: Allergic Reactions to Penicillin. Lancet 1:177 (Feb. 10) 1945.

HYGIENE OF THE ANUS AND RECTUM

J. Gerendasy, M.D., Elizabeth, N. J.

The proper care of the terminal bowel presupposes as its object the prevention of local disease. In this is included the care of minor ano-rectal disorders. To accomplish this, emphasis in the present article will be placed on proper ano-rectal hygiene. The importance of the subject is not sufficiently stressed. This is indicated by the paucity of articles on this subject in proctologic literature.

It is common experience to find most individuals ignorant of, or careless, with regard to personal cleanliness of the rectal outlet. Education in this important prophylactic habit should begin in childhood. Every effort should be made by parents and physicians to give instruction in sound bowel hygiene.

From early childhood, constipation appears to be the most common cause of digestive dysfunction: Distress commonly due to constipation ,varies from severe abdominal pain with nausea and flatulence to symptoms of hunger pain not readily distinguishable, particularly in the adult, from that of peptic ulcer. The universal tendency to correct this with a laxative or enema is a highly pernicious habit. That so many people are addicted to the use of purgatives is largely the result of misleading commercial advertising. The exploitation of the public in this particular is a disgrace to modern civilization.

The forceful emptying of the intestinal tract of its normal contents is at best of questionable value. The disadvantages such as dehydration, nervous irritability, loss of nutrition and the danger, particularly in an unsuspected attack of appendicitis, is not sufficiently stressed.

Another aspect of the problem of laxation is the consequent irritation and soilage of the rectal outlet. It is a potent factor in the pathogenesis of ano-rectal diseases. The local injury may be caused by mechanical trauma (hard or scybalous stool), bacterial invasion, chemical irritation (indol and skatol) or an allergic reaction. In each instance there is an inflammatory reaction. This explains the origin of the more common minor ano-rectal lesions, such as cryptitis, papillitis, analitis (anusitis), pruritus ani and anal spasm. They are the precursors of the more serious disorders affecting the terminal bowel.

The application of active therapeutic measures begins with those simple methods which correct constipation and adequately cleanse the parts following defecation. Faulty, careless cleansing is the common practice among people, irrespective of their station in life. This is shown by the fact that the "well to do" suffer with the identical rectal diseases found in the poor.

When the individual presents himself as a patient it is a common experience to find the peri-anal parts soiled and the rectum containing either a hard or a soft stool. The physician's duty is to establish a routine of digestive hygiene which will correct these conditions. To obtain the proper desideratum, the following rules should be observed (Kantor):

1. Meals should be taken on time.
2. Three meals a day are sufficient for normal people.
3. Food should be properly chewed.
4. The normal dietary should include all the chief classes of foods: Milk, butter, eggs; cereals; meat and fish; green and starchy vegetables; fruit.
5. A definite amount of water should be drunk daily, between meals (up to two quarts for an adult).
6. The bowels should be moved regularly without cathartics preferably after breakfast. Daily concentrated thought should be given to this important function until accomplished.
7. The mouth and teeth should be kept in good order.

These general principles with proper anal hygiene universally practiced "from the beginning" would undoubtedly prevent much future ano-rectal disorders.

The peri-anal skin is variably hairy and contains numerous sweat glands. Some soiling at the time of defecation is certain. It is thus a region of skin which requires more cleansing

than any other, and invariably gets less. The commonly used dry toilet paper as a detergent is highly unsatisfactory. Healthy tissues in this area are able to withstand injury for some time. However, with continued irritation from improper bowel habits, the parts become vulnerable to bacterial invasion.

The proper cleansing of the anal skin after defecation necessitates the application of a non-irritating and cleansing agent. Ordinarily water applied with a soft tissue or Kleenex is sufficient. In the presence of local irritation an antiseptic baby oil commonly sold on the market admirably answers the purpose. This should be applied with pledgets of cotton or soft cloth. In any event reapplication of the detergent is repeated until all fecal stain is removed.

In the presence of the mild inflammatory ano-rectal conditions enumerated above simple prophylactic measures are indicated. A small warm enema of plain water or normal saline solution should be used daily following evacuation of the bowel. The enema may be repeated and immediately expressed after each injection. A two-ounce baby rectal syringe will answer the purpose. The purpose of this procedure is to cleanse the lower rectum and anal canal in order to prevent fecal irritation of the parts. The anal verge is then gently dried with cotton. A five per cent sulfathiazol ointment is then applied into the anal canal with the cotted finger or a suppository containing grains 1½ of the drug in 30 grains of cocoa butter may be inserted into the rectum once or twice daily. The infection responds very satisfactorily to this treatment. Following the rules for normal bowel habit outlined above will prevent a recurrence of the infection.

CONCLUSION

Ano-rectal hygiene is a much neglected form of prophylactic medicine. It is the duty of the medical profession to educate the public in this matter. Normal bowel habits and routine personal cleanliness of this area should begin in childhood for best results. By this means the more serious disorders common to this area may be obviated.

THIOURACIL AND ANGINA PECTORIS

Treatment with thiouracil proved effective in 7 out of 10 patients with angina pectoris, 4 of whom became entirely symptom free during the treatment.

Clinical improvement coincided rather closely with the fall of the metabolic rate and failed to occur in those patients whose basal metabolic rate did not decrease.

Replacement of thiouracil by placebos without the patient's knowledge was followed by a partial or complete recurrence of the anginal symptoms, coinciding with a return of the basal metabolic rate toward its former level within ten days to seven months following discontinuation of the thiouracil medication.

The thyroid hormone, even in physilogic amounts, sensitizes the heart muscle to the anoxiating toxic action of epinephrine. Thiouracil exerts an opposite, heart-protecting effect.

In view of these and many other experimental and clinical facts the efficacy of "functional thyroidectomy" through thiouracil is ascribed to a diminution of myocardial sensitivity to heart-anoxiating, angina-producing epinephrine and sympathin discharges.—Wilhelm Raab, J. A. M. A., Vol. 128, No. 4, p. 249.

FEMALE INFERTILITY

1. Either the husband or the wife may be responsible for her failure to conceive; usually both are at fault and both must be examined thoroughly.

2. The diagnostic survey of such cases should be concerned with (a) the wife's general physical condition, (b) the status of her genital organs, (c) spermatogenesis, (d) delivery of semen to the cervix, (e) ascent of spermatozoa into the uterus, (f) patency of the oviducts, (g) ovulation and (h) the ability of the endometrium to receive and nourish a fertilized egg.

3. All physicians must search more carefully for deficiencies in seminal fluid; husbands should be referred to an interested urologist if the semen is not absolutely normal.

4. Most childless marriages result from a multiplicity of factors; all must be systematically eliminated.

5. One is likely to fail in the management of infertility cases unless one receives wholehearted coöperation from the husband as well as the wife; both must submit to the entire diagnostic study and both must follow through with all indicated treatment.—G. H. Gardner, J. A. M. A., Vol. 128, No. 4, p. 245.

VETERANS CARE PROGRAM

The original contract between Medical Service Administration and Veterans Administration was published on page 38 of the February *Journal* and a reprint was mailed to each member of the Society.

On February 7, 1946, paragraph 5 of the Contract was changed to read as follows:

* * * * * * * *

(5) "Medical Service Administration will bill Veterans Administration for all authorized services rendered at the end of each month. Veterans Administration will remit in accordance with such bill within a reasonable time after receipt thereof."

FEE SCHEDULE

Changes were made in certain items of the fee schedule to accord with the reaction of physicians who attended various County Society meetings at which the schedule was discussed. These changes involved the following items which now read:

II. ABDOMINAL SURGERY

110	Cholecystotomy	$135.00
124	Meckel's diverticulum, excision of	135.00

III. AMPUTATIONS

201	Upper arm	135.00
202	Forearm	108.00
203	Finger, one	27.00
205	Foot	135.00
206	Hand	108.00
207	Leg	135.00
208	Thigh	162.00
209	Toe	27.00

V. DISLOCATIONS

401	Carpal bone, one	43.20
402	Carpal bone, each additional	10.80
403	Clavicle	43.20
404	Elbow	54.00
408	Knee	64.80
409	Mandible	27.00
410	Metacarpal bone, one	27.00
411	Metacarpal bone, each additional	10.80
412	Metatarsal bone, one	27.00
413	Metatarsal, each additional	10.80
415	Patella	54.00
417	Rib, on basis of home, office or hospital calls	
418	Shoulder	43.20
419	Shoulder, recurrent or habitual (non-oper.)	54.00
421	Tarsal bones, each additional	10.80
422	Thumb	16.20
423	Toe, one	16.20
424	Toe, each additional	10.80

VII. COMPOUND FRACTURES

601	Carpal bone, one	108.00
603	Clavicle	108.00
604	Coccyx (coccygectomy)	81.00
607	Fibula	81.00
608	Fibula, suture or plating	135.00
611	Humerus	135.00
612	Humerus, suture or plating or extension	162.00
613	Malar bone	81.00
614	Mandible (wiring if necessary)	108.00
615	Metacarpal, one	54.00
620	Patella	108.00
621	Patella, suture or plating	135.00
622	Pelvis	108.00
626	Rib, one	54.00
630	Skull, vault (requiring operation)	135.00
631	Sternum (open reduction or bone graft)	162.00
632	Tarsal bone	108.00
635	Tibia, suture or plating	108.00
637	Tibia and fibula, suture or plating	135.00
638	Toe, one	27.00

VIII. SIMPLE FRACTURES

701	Carpal bone, one	54.00
704	Coccyx—on basis of home, office or hospital calls	
705	Femur	108.00
707	Tibia or fibula, including Potts' fracture	81.00
709	Finger, one	27.00
711	Humerus	81.00
712	Humerus, suture, plating or extension	135.00
716	Metacarpal bone, one	43.20
718	Metatarsal bone	43.20
720	Nasal bones	27.00
722	Patella, suture or plating	135.00
724	Pelvis, suture or plating	162.00
727	Rib, one—Office, home or hospital call basis	
729	Sacrum—Office, home or hospital call basis	
732	Sternum—Office, home or hospital call basis	
733	Tarsal bone, one	54.00
735	Toe, one	27.00

IX. GENERAL SURGERY

804	Breast, resection of (simple)	81.00

X. JOINT RESECTIONS

901	Elbow joint, excision of	162.00
903	Knee joint, excision of	162.00
905	Wrist joint, excision of	162.00

XXVII. RADIUM AND X-RAY THERAPY

2601	Radium therapy per milligram hour (Minimum fee $5.40—Maximum expenditure not to exceed $108.00 unless additional authorization is obtained)	.054
2602	X-ray therapy, deep, for treatment	$10.80 to $16.20
2603	X-ray therapy, superficial treatment (Maximum expenditure for x-ray therapy is not to exceed $100.80 unless additional authorization is obtained)	5.40

INITIAL PRESUMPTION OF SERVICE-CONNECTION IN VETERANS' CASES

Circular No. 26 of Veterans Administration dated January 31, 1946, provides that pending the adjudication of a veteran's claim for medical services, the Regional Medical Director may authorize payment for service on *presumptive evidence of service connection* up to the time this claim is officially adjudicated. If the official decision is not in favor of "service connection" payment for services will be discontinued as of the date of such a decision.

If a patient presents himself to you and you believe the disorder is "service connected" you should notify Medical Service Administration which will in turn forward you a blank upon which to request authority for payment. When you return this blank to M. S. A. we will make every effort to expedite the decision of the Regional Medical Director.

The significant words in the circular are: *Authorization is hereby granted to furnish outpatient treatment to veterans at the expense of the Veterans Administration independent of whether the need . . . is emergent on a basis of . . . prima facie eligibility. . . . Treatment may be authorized . . . on a fee basis pending adjudication of . . . claim.*

Circular No. 26 also authorizes emergency hospitalization in contract (not governmental) hospitals at the expense of the Veterans Administration. It should be understood, however, that in hospitals which do not have a contract with V. A. (based upon their actual costs), the only payment for hospitalization which can be made by V. A. is at the rate of $3 per day for ward accommodations, $4 per day for semi-private, and $5 per day for private room accommodations.

The relevant section of the circular is printed in full below. Physicians may want to copy this section or note a citation to it on the fee schedule reprint which was distributed last month to all members of the Society and which was later amended as published in this issue. The extract follows:

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CIRCULAR NO. 26
VETERANS ADMINISTRATION
WASHINGTON, D. C.
31 JANUARY 1946.

II. Authority to furnish outpatient treatment at field stations or through private or designated examiners and to furnish hospitalization in private hospitals to veterans pending adjudication of their claims. 1. In order to eliminate any delay in rendering out-patient treatment or emergent hospitalization in private or contract hospitals, pending adjudication for claims or pension, and in order to render full service to disabled veterans, authority is bereby granted, effective immediately, to furnish out-patient treatment to veterans at the expense of the V. A. independent of whether the need for outpatient treatment is emergent or not on a basis of a determination of prima facie eligibility. In other words, sbould there be a determination properly made by the Chief Medical Officer or his designate, that prima facie service-connection is established hy the evidence of record, including tbe veteran's statement, out-patient treatment may be authorized at our own field stations or on a fee basis, pending the adjudication of the veteran's claim.

2. Hospitalization in a private or contract hospital may also be authorized under the conditions outlined above in an emergency. It will be distinctly understood and tbe veteran so informed that the furnishings of emergency hospitalization or out-patient treatment does not imply tbat, for pension purposes, the decision on bis claim will be in favor of service connection. The veteran will be further informed that, if his claim for pension is disallowed, he will not thereafter be entitled to any furtber out-patient treatment and that, as bospitalization in private or contract hospitals is restricted to service-connected cases, subsequent rehospitalization in a private hospital or a hospital with whicb a contract is in force with the V. A. may not be authorized.

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VETERANS CARE NEWS NOTES

STARTING DATE DELAYED

An unexpected delay in adjusting administrative methods with the Veterans Administration may delay the start of the plan by about two weeks.

REQUESTS FOR INFORMATION

The Medical Service Administration asks publication of the following notice:

Many requests are being received for "full information" or for "more information" about the Veterans Care Plan. It has been impossible for the clerical staff to answer personally and in adequate detail all these requests. You will be informed of full details through the pages of this *Journal* or through releases sent out from time to time by the Society.

FEMALE VETERANS

For non-service-connected disabilities, medical care of women veterans is limited to emergency conditions treated in a hospital. Females treated in the office or at home for non-service-connected disorders will not be processed through this Plan. Hospital care for non-service disabilities in women veterans is limited to those who cannot afford to pay costs of hospitalization and care.

THE VETERANS MEDICAL CARE PLAN OF NEW JERSEY

Questions and Answers

1. *What is the Veterans Medical Care Plan?*

   It is a Plan to be operated by our Medical Service Administration under which a veteran with a service-connected disability may receive (a) the necessary physical examinations by private physicians near his home, and (b) medical care from physicians of his own choice in his own community.

2. *May the Veteran choose his own physician?*

   For treatment, yes. But not for physical examination. Authorized physical examinations will be referred by M. S. A. to specified physicians. This is because many of these involve specialized examinations, such as neuro-psychiatric, orthopedic or heart which must be made by appropriate specialists. However, general physical examinations will be referred to general practitioners.

   In receiving authorized treatment, the veteran will be allowed free choice of physician from among those registered with M. S. A. as Participating Physicians.

3. *How many Participating Physicians have been registered?*

   A complete roster is not ready at this time. However, the list is growing rapidly and it is believed that practically every member of The Medical Society of New Jersey will eventually submit his name to M. S. A. as willing to participate.

4. *How does the Veteran apply for care?*

   The veteran should apply directly to the Veterans Administration, at its branch offices in Paterson, Newark, Trenton, Camden or Atlantic City, by telephone, letter or personal visit. Application forms may also be obtained at any Red Cross office, Veterans Community Center or American Legion Office. Any treatment authorized will then be routed by V. A. through M. S. A.

5. *How does the Veteran obtain care in emergencies?*

   He still must received authorization from the V. A. If a veteran applies for emergency care, we hope the care will always be rendered. If there is presumptive evidence of "service connection", the V. A. will assume responsibility up to the time the claim is adjudicated. If the claim is finally decided against the veteran, the responsibility of the V. A. ceases as of that date. The determination of service connection and authority for treatment in such cases may be determined, according to recent instructions, by the personnel of the Regional Office in Newark. If such an instance arises in your practice and is reported to M. S. A., we will attempt to expedite authority for treatment.

6. *After the Veteran files his request for treatment, how long must he wait for approval or disapproval?*

   If the veteran filed a claim when separated from the service, his record is on file at the Regional Office in Newark and the decision should be made promptly. If he did not file a claim when separated from service there will be a delay until a transcript can be obtained from Washington. However, if it is an emergency with presumptive evidence of service connection, this delay will not occur. When treatment is authorized the necessary papers will be sent to the veteran through M. S. A. and he will choose his physician from the list forwarded to him.

7. *Who determines whether a veteran's disability is service connected?*

   The Veterans Administration is the only body which can make this determination.

8. *May the physician make a charge for authorized services above the amount paid by V. A.?*

   No. When a physician registers with M. S. A. as a Participating Physician, he agrees to accept the fees stated in the schedule as complete payment for authorized services.

9. *May a veteran be admitted to a community hospital for care?*

   Yes, in hospitals which have contracted with V. A. for hospitalization of veterans. The list of contracting hospitals is growing rapidly and it is hoped that every community hospital will soon have such a contract.

10. *Are women veterans entitled to care under this Plan?*

    Yes. In fact, since women cannot be admitted to Veterans Administration Hospitals for non-service-connected disabilities, it is contemplated that they may receive full medical care to include non-service-connected disabilities under the Plan providing they submit a statement that they cannot afford to pay for medical care in case of non-service-connected disa-

bilities. This will not apply to obstetrical care.

11. *Does the Plan cover services rendered in the patient's home, physician's office and hospital?*

Yes. For service-connected disabilities.

12. *Are x-ray, clinical laboratory and consultation services available under the Plan?*

Yes. When you received a patient for examination or treatment there will be inserted with the report blank a special form upon which to request authorization for any additional service which you feel necessary. This request should be submitted promptly to V. A. through M. S. A. which will use every effort to expedite action.

13. *Is nursing service available?*

No. This Plan is limited to physicians' services.

14. *What are the functions of Medical Service Administration in this Plan?*

The Board of Trustees of The Medical Society of New Jersey designated M. S. A. to operate the financial arrangement of the Plan. As such it will be responsible for keeping financial records, billing the Veterans Administration and for the payment of physicians for authorized services rendered. M. S. A. is allowed 8 per cent of the fee to cover operating costs, and will be glad to be of any service to participating physicians or veterans so long as the expense of this service can be kept within the amount allowed for operating expenses.

15. *What physicians may participate?*

Any member of The Medical Society of New Jersey.

If you have not registered with M. S. A., please write a letter to Medical Service Administration, 31 Clinton Street, Newark 2, N. J., using the form suggested below.

I agree to participate in the Veterans Medical Care Plan as arranged between The Medical Society of New Jersey and the Veterans Administration.

I am in general practice.....

I am doing special work in.....

I am confining my work entirely to.....

I can accommodate.....physical examinations a month in my office.

.....
Name (write legibly)

.....
Address

Member of

.....County Society

HOSPITAL EXPANSION IN THE ORANGES

A joint committee of the *Orange Memorial Hospital* and the *New Jersey Orthopaedic Hospital* have announced a plan to establish a medical center for the Oranges and vicinity. The project calls for replacing the present Orthopaedic Hospital with a new building adjoining the Orange Memorial. While retaining their separate entities these two institutions would be enabled to work together in close coöperation. Also embraced in the plan is the conversion of the present Orthopaedic Hospital building into a convalescent institution which would solve for the Oranges a problem that is becoming increasingly desperate throughout the state. The medical profession wishes these hospitals success in raising the necessary funds for the implementation of their project.

STATE ACTIVITIES

NUTRITION IN EVERYDAY PRACTICE

S. WILLIAM KALB, M D., Newark, N. J.

Nutrition Representative, Tuberculosis and Adult Disease Control Advisory Committee to the Subcommittee on Public Health

RECOMMENDED DIETARY ALLOWANCES

REVISED 1945

Food and Nutrition Board, National Research Council

	Calories	Protein grams	Calcium grams	Iron mg.	Vitamin A I. U.[2]	Thiamine mg.[3]	Riboflavin mg.[3]	Niacin (Nicotinic acid) mg.[3]	Ascorbic acid mg.	Vitamin D I. U.
Man (154 lb., 70 kg.)										
Sedentary	2500	70	0.8	12[4]	5000	1.2	1.6	12	75	[5]
Moderately active	3000	70	0.8	12[4]	5000	1.5	2.0	15	75	[5]
Very active	4500	70	0.8	12[4]	5000	2.0	2.6	20	75	[5]
Woman (123 lb., 56 kg.)										
Sedentary	2100	60	0.8	12	5000	1.1	1.5	11	70	[5]
Moderately active	2500	60	0.8	12	5000	1.2	1.6	12	70	[5]
Very active	3000	60	0.8	12	5000	1.5	2.0	15	70	[5]
Pregnancy (latter half)	2500[6]	85	1.5	15	6000	1.8	2.5	18	100	400 to 800
Lactation	3000	100	2.0	15	8000	2.0	3.0	20	150	400 to 800
Children up to 12 yrs.[7]:										
Under 1 yr.[8]	100/2.2 lb. (1 kg.)	3.5/2.2 lb. (1 kg.)	1.0	6	1500	0.4	0.6	4	30	400 to 800
1–3 yrs. (29 lb., 13 kg.)	1200	40	1.0	7	2000	0.6	0.9	6	35	400
4–6 yrs. (42 lb., 19 kg.)	1600	50	1.0	8	2500	0.8	1.2	8	50	400
7–9 yrs. (55 lb., 25 kg.)	2000	60	1.0	10	3500	1.0	1.5	10	60	400
10–12 yrs. (75 lb., 34 kg.)	2500	70	1.2	12	4500	1.2	1.8	12	75	400
Children over 12 yrs.[7]:										
Girls, 13–15 yrs. (108 lb., 49 kg.)	2600	80	1.3	15	5000	1.3	2.0	13	80	400
16–20 yrs. (119 lb., 54 kg.)	2400	75	1.0	15	5000	1.2	1.8	12	80	400
Boys, 13–15 yrs. (103 lb., 47 kg.)	3200	85	1.4	15	5000	1.5	2.0	15	90	400
16–20 yrs. (141 lb., 64 kg.)	3800	100	1.4	15	6000	1.8	2.5	18	100	400

This is the latest revision of "Recommended Dietary Allowances" which has been prepared by the Food and Nutrition Board of the National Research Council. The tabulated data and footnotes are important for every physician to read and digest. They contain up-to-the-minute information and recommendations. Permission was kindly granted to print this revised table with footnotes in the current issue of *The Journal.*

[1] Tentative goal toward which to aim in planning practical dietaries; can be met by a good diet with a variety of natural foods. Such a diet will also provide other minerals and vitamins, the requirements for which are less well known.

[2] The allowance depends on the relative amounts of vitamin A and carotene. The allowances of the table are based on the premise that approximately two-thirds of the vitamin A value of the average diet in this country is contributed by carotene and that carotene has half or less than half the value of vitamin A.

[3] For adults (except pregnant and lactating women) receiving diets supplying 2,000 calories or less, such as reducing diets, the allowances of thiamine, riboflavin, and niacin may be 1 mg., 1.5 mg., and 10 mg. respectively. The fact that figures are given for different calorie levels for thiamine, riboflavin, and niacin does not imply that we can estimate the requirement of these factors within 500 calories, but they are added merely for simplicity of calculation. Other members of the B complex also are required, though no values can be given. Foods supplying adequate thiamine, riboflavin, and niacin will tend to supply sufficient of the remaining B vitamins.

[4] There is evidence that the male adult needs little or no iron. The allowance will be provided if the diet is satisfactory in other respects.

[5] For persons who have no opportunity for exposure to clear sunshine and for elderly persons, the ingestion of small amounts of vitamin D may be desirable. Other adults probably have little need for vitamin D.

[6] During the latter part of pregnancy the allowance should increase approximately 20 per cent over the preceding level. The value of 2500 calories represents the allowance for pregnant, sedentary women.

[7] Allowances for children are based on the needs for the middle year in each group (as 2, 5, 8, etc.) and are for moderate activity and for average weight at the middle year of the age group.

[8] Needs of infants increase from month to month

with size and activity. The amounts given are for approximately 6 to 8 months. The dietary requirements for some of the nutrients such as protein and calcium are less if derived largely from human milk.

Further Recommendations

Fat. There is available little information concerning the human requirement for fat. Fat allowances must be based at present more on food habits than on physiological requirements. While a requirement for certain unsaturated fatty acids (the linoleic and arachidonic acids of natural fats) has been amply demonstrated with experimental animals, the human need for these fatty acids is not known. In spite of the paucity of information on this subject there are several factors which make it desirable that fat be included in the diet to the extent of at least 20 to 25 per cent of the total calories and that the fat intake include "essential" unsaturated fatty acids to the extent of at least 1 per cent of the total calories. At higher levels of caloric expenditure, e. g., for a very active person consuming 4500 calories and for children and adolescent persons, it is desirable that 30 to 35 per cent of the total calories be derived from fat. Since foodstuffs such as meat, milk, cheese, and nuts may be expected to contribute "invisible" fat to the extent of from one-half to two-thirds of the total amounts of fat implied by the above proportions of the total calories, it is satisfactory to use separated or "visible" fats such as butter, margarine, lard, and shortenings only to the extent of one-third to one-half of the amounts indicated.

Copper. The requirement for copper for adults is about 1 to 2 mg. daily. Infants and children require approximately 0.05 mg. for each kilogram of body weight. The requirement for copper is approximately one-tenth that for iron. A good diet normally will supply sufficient copper.

Iodine. The requirement for iodine is small, probably about 0.002 to 0.004 mg. daily for each kilogram of body weight, or a total of 0.15 to 0.30 mg. daily for the adult. This need is met by the regular use of iodized salt; its use is especially important in *adolescence* and *pregnancy.*

Phosphorus. Available evidence indicates that the phosphorus allowances should be at least equal to those for calcium in the diets of children and of women during the latter part of pregnancy and during lactation. In the case of other adults the phosphorus allowances should be approximately 1.5 times those for calcium. In general it is safe to assume that if the calcium and protein needs are met through common foods, the phosphorus requirement also will be covered, because the common foods richest in calcium and protein are also the best sources of phosphorus.

Vitamin K. The requirement for vitamin K usually is satisfied by any good diet. Special consideration needs to be given to newborn infants. Physicians commonly give vitamin K either to the mother before delivery or to the infant immediately after birth.

Salt. The needs for salt and for water are closely interrelated. A liberal allowance of sodium chloride for the adult is 5 grams daily, except for some persons who sweat profusely. The average normal intake of salt is 10 to 15 grams daily, an amount which meets the salt requirements for a water intake up to 4 liters daily. When sweating is excessive, one additional gram of salt should be consumed for each liter of water in excess of 4 liters daily. With heavy work or in hot climates 20 to 30 grams daily may be consumed with meals and in drinking water. Even then, most persons do not need more salt than usually occurs in prepared foods. It has been shown that after acclimatization persons produce sweat that contains only about 0.5 gram to the liter in contrast with a content of 2 to 3 grams for sweat of the unacclimatized person. Consequently after acclimatization, need for increase of salt beyond that of ordinary food disappears.

Water. A suitable allowance of water for adults is 2.5 liters daily in most instances. An ordinary standard for diverse persons is one millimeter for each calorie of food. Most of this quantity is contained in prepared foods. At work or in hot weather, requirements may reach 5 to 13 liters daily. Water should be allowed *ad libitum,* since sensations of thirst usually serve as adequate guides to intake except for infants and sick persons.

COMMITTEE ON LABORATORY MEDICINE

The Medical Society of New Jersey has created a new committee on Laboratory Medicine, advisory to its sub-committee on Medical Practice. Personnel of this committee, all approved by the New Jersey Society of Clinical Pathologists, is as follows: Dr. Asher Yaguda, Chairman, Newark; Dr. Hobson Davis, Paterson; Dr. S. A. Goldberg, Newark; Dr. Frank Konzelmann, Atlantic City, and Dr. Carlos Pons, Asbury Park.

NEW RATES FOR MEDICAL CARE OF INDIGENT

The Division of Municipal Aid of the State of New Jersey announces that effective March 1, physicians' fees for the care of patients receiving public assistance from municipalities will be: $1.50 per office visit, $2.50 per home visit (day), and $4.00 for night calls. A mileage rate is not included. These represent the maximum figures at which the Department will reimburse the municipalities. Some communities may pay higher rates and make up the difference out of local tax funds.

WITH NEW JERSEY MEDICAL AUTHORS

Compiled by MILDRED V. NAYLOR, Librarian, Academy of Medicine

It is requested that any New Jersey physician who publishes an article outside the state, notify the Editorial Office in Trenton, giving the title of the paper and the name of the periodical, as well as the month, date, volume and page number. It would also be helpful to this office if members would notify us of articles published by their colleagues.

BERKE, RAYNOLD N.—Hackensack
Blepharoptosis. Arch. Ophthal. 34: 434-450, Nov.-Dec. '45

BERNSTEIN, ARTHUR—see Parsonnet, Aaron E.

BRIGGS, HENRY, and SIDNEY KEATS—East Orange
Clinical experience in the treatment of low back and sciatic pain associated with disorders of the intervertebral disc. J. Med. Soc. New Jersey 43: 13-18, Jan. '46

EAGLETON, WELLS P.—Newark
Co-author of Jackson, C., & Jackson, C. L. ed—Diseases of Nose, Throat and Ear. Saunders. 1945.

GOLDBERG, BERNARD R.—Newark
Arachnoiditis and paralysis following spinal anaesthesia. J. A. M. A., 129: 664-667, Nov. 3, '45

HAZARD, W. G.—Pennington
Health facilities in New Jersey plants. Indust. Med. 15: 15-22, Jan. '46

HEWSON, GEORGE F.—Newark (in service)
Procaine toxicity with report of a near fatal case. Mil. Surgeon 97: 489-492, Dec. '45

KEATS, SIDNEY—see Briggs, Henry

KENNEY, JOHN A.—Montclair
Medicine then and now. J. Natl. Med. A. 38: 27-30, Jan. '46

KLOSK, EMANUEL—see Parsonnet, Aaron E.

MILLER, RALPH—see Parsonnet, A. E.

OTT, WALTHER H.—see Seeler, Albert O.

PARSONNET, AARON E.; RALPH MILLER, ARTHUR BERNSTEIN and EMANUEL KLOSK—Newark
Bigeminy; an electrocardiographic study of bigeminal rhythms. Am. Heart J. 31: 74-92, Jan. '46

PLATT, EDWARD V.—Haddon Heights (in service) (with others)
Experience in the management of the abdominal wounds of warfare. Surg., Gynec. & Obst. 82: 174-193, Feb. '46

POLOWE, DAVIS—Paterson
Blood amylase activity in pancreatitis and other diseases. Surg., Gynec. & Obst. 82: 115-130, Feb. '46

READ, HILTON S.—Atlantic City (in service) (with others)
Neurosyphilis; its diagnosis and treatment. J. Med. Soc. New Jersey 43: 5-12, Jan. '46

SEELER, ALBERT O., and WALTHER H. OTT—Rahway (Merck & Co.)
Studies on nutrition and avian malaria. IV. Protein deficiency. J. Infect. Dis. 77: 181-184, Nov.-Dec. '45

SHAUL, JOHN F.—Bloomfield (in service) (with H. B. Conaway)
Acute infective jaundice (acute hepatitis) occurrence at a North African Base Hospital. U. S. Nav. M. Bull. 46: 203-210, Feb. '46

SNEDECOR, SPENCER T.—Hackensack (in service)
Muscle and joint examination chart. Arch. Phys. Med. 27: 33-36, Jan. '46

M.D. VACANCIES IN U.S.P.H.S.

The United States Public Health Service announces examinations for appointment to the Regular Corps. There are vacancies in the grade of Assistant Surgeon and in the grade of Senior Assistant Surgeon. Starting pay is $3411 a year for Assistant Surgeon with dependents and $3991 a year for Senior Assistant Surgeon. Promotions are at regular intervals and retirement pay at the age of 64 is $4500 a year. And at any age, there is a disability retirement at three-fourth pay. The Service includes 30 days' vacation with pay each year.

Next examination in this area will be held in New York City on May 7 and 8. Application forms may be obtained by writing to the Surgeon General, United States Public Health Service, Washington 25, D. C.

OBITUARIES

DR. FREDERICK L. BROWN

Dr. Frederick L. Brown, 63, of New Brunswick, died on January 29 in the New York Presbyterian Hospital following a cerebral operation. Dr. Brown was born in Somerville and after being graduated from Princeton University became an executive for the American Locomotive Company. Some years later he matriculated at the College of Physicians and Surgeons of Columbia University, from which he was graduated in 1910. At the conclusion of his internship he moved to New Brunswick where he remained in private practice until his death.

Dr. Brown was a diplomate of the American Board of Internal Medicine, Fellow of the American College of Physicians and a past president of the Middlesex County Medical Society. He was chairman of the County Society's Procurement and Assignment Committee during the war, and chief of obstetrics at the Middlesex General Hospital from 1929 to 1931. Since 1931 he had been chief of the medical service at that hospital.

DR. EDWARD L. DODD

Dr. Edward L. Dodd, former medical examiner for the Pennsylvania Railroad, died at his home in Belleville on February 19, at the age of 74. Born in Newark, Dr. Dodd was graduated from Princeton University and studied medicine at the College of Physicians and Surgeons where he was in the class of 1900.

DR. A. LOUIS GRAMSCH

Dr. A. Louis Gramsch, former chief physician at the New Jersey State Sanatorium at Glen Gardner, died February 1 at the age of 58 in the Hackensack Hospital after a brief illness. Dr. Gramsch was at one time acting superintendent of Bergen Pines and prior to that was superintendent of Southern Pines Sanatorium, North Carolina. He was a graduate of Flower Medical College, class of 1910.

DR. JAMES GRIEVE

Dr. James Grieve, 58, a Perth Amboy practitioner for 22 years, died at the Perth Amboy General Hospital on January 27, 1946. Dr. Grieve was born in England, came to the United States in childhood and was graduated from Long Island College of Medicine in 1921. He was attending anesthesist at the Perth Amboy General Hospital and a director of the West Amboy Building and Loan Association.

DR. HARRY V. HUBBARD

Dr. Harry V. Hubbard died in the Muhlenberg Hospital, Plainfield, at the age of 73 on January 29. A graduate of the University of Vermont College of Medicine in 1898, he practiced in that state until 1906 when he moved to Plainfield.

He became medical director of the Muhlenberg Hospital and for 20 years was associate professor at the Post Graduate Medical School in New York. He was engaged in the active practice of ophthalmology and otolaryngology in Plainfield between 1923 and 1946. Dr. Hubbard was a director of the Plainfield Savings Bank and president of the Community Concert Association and of the board of trustees of the Congregational Church.

APPEALS FROM AROUND THE WORLD

Two appeals to the physicians in New Jersey from their brethren in other parts of the world have recently come to the State Society. One is from the Bureau of Science of the *Commonwealth of the Philippines,* reporting that their library was destroyed by the Japanese and asking for donations of books, magazines or reprints. Doctors who wish to help are advised to send such periodicals to: Scientific Library, Bureau of Science, Department of Agriculture, Manila, P. I.

Another appeal has come from the physicians of *The Netherlands* for second-hand medical equipment, particularly items useful for minor surgery in the doctor's office. The Dutch physicians who refused to collaborate with the occupying Nazi army were stripped of their equipment and are now struggling to render service to the Dutch citizenry. Such items of equipment should be sent to Dr. Julius Levy, 143 East State St., Trenton 8, who will see that they are forwarded to proper sources in The Netherands.

NEW ARMY MEDICAL LIBRARY PROPOSED

Hearings before a budget committee of Congress will determine whether a new building will be erected to house the greatest collection of medical books in the world, the Army Medical Library. The present building was constructed in 1887 and is now totally inadequate for the needs for this library. Congress is being asked to appropriate $10,000,000 and the coöperation of the medical profession is being enlisted in this campaign.

THE BULLETIN BOARD

"Is a Child Health Congress the Missing Link in the Child Care Program?" This is the theme of a panel discussion to be held Wednesday, April 3, at Hotel Pennsylvania, New York, led by representatives of the American Medical Association, the U. S. Public Health Service, the Children's Bureau and the American Academy of Pediatrics. For details write to Dr. Stanley Nichols, 517 Broadway, Long Branch, N. J.

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"Lessons from Military Psychiatry" will be the title of a talk by Brigadier General Menninger, Army's Chief of Neuropsychiatric Service, to be delivered Friday, April 26, at 4 p. m. in the Bellevue Psychiatric Division, 30th Street, east of First Avenue, New York City.

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The Washington Institute of Medicine announces two new publications, the *Quarterly Review of Psychiatry and Neurology,* edited by a board of well-known psychiatrists and neurologists, under the direction of Dr. Winfred Overholser; and the *Quarterly Review of Urology,* whose editor-in-chief is Dr. H. J. Jewett. These Reviews promise to bring together abstracts of significant advances in their respective specialities and either may be obtained at an annual subscription of $9.00 from the Washington Institute of Medicine, 1720 M St., N. W., Washington 6, D. C.

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Physicians and dentists are invited to participate in a discussion on the Control of Oral Infections to be held under the joint auspices of the Passaic County Medical and Dental Societies at 9 p. m., Tuesday, March 19, in the Freeholders' Room of the County Administration Building, Paterson, N. J.

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The Long Island College of Medicine announces the purchase of a large tract of land across the street from Kings County Hospital in Brooklyn, to be used as an additional campus for the College where the basic science and research facilities will be constructed. The Henry Street building, however, will remain the major teaching center for the College.

Professor William Goldring of New York University Medical College will give a talk on the treatment of hypertension at the Roosevelt Hospital, Metuchen, N. J., Wednesday, March 20, at 9:00 p. m., under the auspices of the Middlesex County Medical Society.

• • •

A graduate course in diseases of the chest will be given at Michael Reese Hospital in Chicago during the week beginning April 1. This will be followed by an elective course in bronchoscopy, pneumothorax or chest surgery at the option of the student. For information write to the American College of Chest Physicians, 500 North Dearborn St., Chicago 10, Ill.

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Announcement has been made of the formation of the National Arthritis Research Foundation to study the causes and treatment of arthritis. President Truman is the honorary chairman, and the project has been endorsed by Surgeon-General Parran and by the editor of the J. A. M. A., both of whom have become sponsors. For further information write to Commissioner Leonard B. Finder, 33 West 42nd St., New York 25, N. Y.

• • •

Volume II of the *Hebrew Medical Journal,* a bilingual publication edited by Dr. Moses Einhorn, has just appeared, and includes sections on medicine in the Bible, old Hebrew Medical Manuscripts, Health Problems in Palestine and Mental Hygiene in Children. While the articles are written in Hebrew, each is followed by an English summary. Subscriptions or information may be obtained from the Hebrew Medical Journal, 983 Park Avenue, New York 28, N. Y.

• • •

A $3500 award awaits the medical author who submits an acceptable book-length manuscript on some phase of medicine for the layman. Closing date is November 1, 1946, and details may be obtained from the W. W. Norton Company, 70 Fifth Avenue, New York 11.

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Dr. J. W. Byrd of Maryland, Past President of the Maryland State Medical Society, will review his state's medical care program before the Middlesex County Medical Society meeting at the Roosevelt Hospital, Metuchen, N. J., on April 17, 1946, at 9 P. M.

COUNTY SOCIETY REPORTS

ATLANTIC COUNTY

Walter B. Stewart, M.D., Reporter

Regular monthly meeting of the *Medical Society of Atlantic County,* held in Atlantic City on February 8th, was preceded by a dinner in honor of the guest speaker, THADDEUS L. MONTGOMERY, M.D., Professor of Obstetrics and Gynecology, Temple University, Philadelphia. His subject was: *Early Diagnosis and Treatment of Pelvic Disease.* Dr. Montgomery stressed the need for complete coöperation between general practitioners and gynecologists with joint meetings every few years to discard outmoded ideas and to discuss the new ones. The family physician should be the first to care for the patient, do a satisfactory pelvic examination, and treat any minor lesions. Too often this is not the case for the following reasons:

(1) The doctor has been inadequately trained in gynecology. But better training is available to most medical students today. (2) He is inadequately equipped. However, not much equipment is needed. (3) Because of false modesty the patient may be unwilling to have the family doctor make the examination. This seldom is true today. (4) The patient goes first to the specialist with her problem. This should be remedied by a closer liaison of patient, family doctor and specialist. This is needed especially for early diagnosis of cancer of the cervix, uterus and ovaries.

A few of the mistakes often made by the average doctor are:

(1) The use of endocrine products in the treatment of bleeding. Hypodermics and pills are too often given instead of a good examination. (2) The assumption that irregular bleeding and spotting is normal in the menopause. (3) The false idea that it is undesirable to examine a patient during bleeding. (4) The false idea that lack of visible lesion means absence of cancer. Dr. McCrae spoke well when he said that more mistakes are made from not looking than by not knowing. Periodic health examinations should be done in women semiannually by the medical practitioner. Thus early cancer may be detected.

Indiscriminate prescribing of endocrine products, especially the estrogens, does more harm than good. These drugs may cause bleeding and obscure a carcinoma of the endometrium, in which case curettage must be done for diagnosis. The question even arises whether sometimes they may cause cancer. Adenocarcinoma of the uterus is on the increase, and perhaps estrogenic therapy has something to do with this trend. Other side-effects of the estrogens are endometriosis and changes in the breasts.

Too much is made of symptoms of the menopause which are entirely normal. Psychotherapy should be used, giving the patient a frank explanation of the facts.

There is a definite need for estrogen therapy in relatively few situations. These are: (1) Progesterone in habitual abortion. (2) Testosterone proprionate in functional menorrhagia. (3) Locally in atrophic vaginitis and in certain vaginal infections, but only in small amounts. Avoid using the estrogens in young children because of the danger of depression of the pituitary gland. (4) Sometimes, treatment of menopausal symptoms with moderate dosage gives good results. Data on their use in other conditions are contradictory.

In difficult decisions when the question of gynecologic surgery arises and the specialist has given his opinion, the practitioner who best knows the patient as a whole should act as arbiter. Most common indications for surgery are: (1) Diagnostic curettage. This, we are doing more often than formerly. (2) Fibroids, increasing in size, bleeding excessively or exerting pressure on surrounding structures. (3) Endometriosis. (4) Cancer of the reproductive tract. Do a complete extirpation in grades 1 and 2; use x-ray for grade 3. (5) Fistula. (6) Prolapse, cystocele, rectocele—if there is enough support available. (7) Ectopic pregnancy. (8) Ovarian cyst.

The speaker was thanked by DR. KONZELMANN for his fine presentation. Several members voiced their appreciation and in discussion of the paper raised a number of questions which Dr. Montgomery answered.

In the business meeting which followed, the Secretary read the minutes of the previous meeting, and DR. BRADLEY, reporting for the Board of Censors, recommended the election of DR. MILTON CUTLER of Hammonton to associate membership. The report was approved. The Treasurer, DR. ALLMAN, reported that for the first time in many years every member of the Society had paid his dues. The President was authorized to negotiate a change of meeting place from the Chelsea Hotel to the Ambassador, our previous meeting place. A dinner and outing in honor of the veteran physicians some time in the spring will be left in the hands of the Entertainment Committee.

BERGEN COUNTY

H. E. Reinhold, M.D., Reporter

Regular meeting of the *Bergen County Medical Society* was held at Bergen Pines, Oradell, N. J., on December 11th, 1945, and was called to order by the President, DR. FREDERICK G. DILGER, at 9:35 p. m.

DR. MARSHALL F. DRIGGS of Englewood and DR. J. LLOYD MORROW of Rutherford were elected to membership.

Speaker of the evening was DR. PAUL BUNN, Assistant Attending Physician, New York Hospital, Division of Infectious Diseases; Instructor in Medicine, Cornell University Medical College, who spoke on *Virus Pneumonia.* He pointed out that this disorder is probably caused by virus and possibly by a streptococcus. The condition is best termed primary atypical pneumonia—cause unknown. Onset is insidious; the x-ray findings diagnostic: the pulmonary signs few or absent. The temperature rises to as high as 103 and resolves by lysis. Cough is severe, dry and painful. The bronchial mucosa is

ulcerated and bronchiectasis is an important complication. The treatment is symptomatic. The sulfonamids and penicillin are useful in preventing or treating secondary infection.

The speaker answered many questions from the floor, and the meeting adjourned to collation at 11 p. m.

Regular meeting of the *Bergen County Medical Society* was held at Bergen Pines, Oradell, N. J., on January 9th, 1946, and was called to order by the President, DR. FREDERICK G. DILGER, at 9:30 p. m.

The Secretary read a letter from the Veterans' Administration, offering a position to an eligible physician with the rating of Rating Specialist Medical. The position is of an administrative nature and carries with it a salary of $4300 per year, for a forty-hour week, with overtime pay on the basis of time and a half. Anyone interested should apply to Joseph O'Hern, Manager, Veterans' Administration, 120 Wall Street, New York 5.

DR. HAROLD I. MARK of Teaneck, DR. PETER J. BONANNO of Tenafly, DR. JOHN MCWHORTER of Englewood, DR. ERIC C. BAYER of Dumont, DR. WILLIAM P. MAGEE of Palisade, DR. EMIL DUL of Garfield and DR. SAMUEL F. BASSETT of Dumont were elected to membership.

Speaker of the evening was DR. M. A. GOLDBERGER, Director of Gynecology at Mt. Sinai Hospital, New York; Associate in Gynecology, Columbia University Medical School, who spoke on *"The Practical Application of Endocrines in Gynecology"*.

Dr. Goldberger described the interrelationship of the various endocrine glands in the female. He described the use of the endrogens in cases of exaggeration of the normal menstrual flow but warned against the undesirable effects such as huskiness of the voice, hirsuitism and complete cessation of the flow. The speaker was unable to find any abnormal hormone findings in cases of dysmenorrhea. Progestoral or the androgens might be helpful in these cases.

Menorrhagia might be due to subinvolution of the uterus, incomplete abortion, submucous fibroids or ovarian disease. In these cases the estrogens in the urine are present in high concentration, due perhaps to low urinary thresholds or poor estrogen metabolism. Treatment includes diagnostic curettage, x-ray, progesterol or the androgens. Use of estrogens in the menopause, according to the speaker, is usually overdone by the practitioner. He recommended the use of estrogenic hormone or stillbestrol for short periods of three weeks with considerable rest between courses. Many other less common endocrine disturbances in the female were described and after a spirited discussion from the floor, the meeting adjourned to collation at 11 p. m.

Regular meeting of the *Bergen County Medical Society* was held at Bergen Pines Hospital, Oradell, on February 12th, 1946, and was called to order by the President, DR. FREDERICK G. DILGER, at 9:30 p. m. The Secretary announced the death of DR. A. L. GRAMSCH, who died at Hackensack Hospital the week before. The secretary was instructed to note his demise on the minutes and send the condolences of the Society to the family.

The secretary announced that the annual banquet of the Bergen County Medical Society would be held on February 27th at the White Beeches Country Club, Haworth, N. J. This year's banquet is dedicated to our members who have served in World War II and invitations have been extended to the veterans to be guests of the Society. A plea for a large attendance was made.

DR. SAMUEL ALEXANDER announced that The Medical Society of New Jersey has signed an agreement with the Veterans' Administration which covers the care of the veterans by private physicians in their community. Dr. Alexander outlined briefly the plan which would be administered through the Medical Service Administration of New Jersey, the State Liaison Committee and the County Liaison Committees. The Liaison Committee for Bergen County is as follows: Dr. Spencer Snedecor, Chairman; Dr. Rudolph C. Schretzmann, Dr. Walter J. Farr, Dr. H. B. Wilson, Dr. G. D. Appold, Dr. L. Burnham, Dr. W. W. Schmidt.

Dr. Alexander urged that all doctors coöperate in this plan and suggested that a Special Meeting be called, so that DR. NORMAN SCOTT could present the plan and discuss it with the members.

Dr. Dilger called a Special Meeting for February 26 at the Bergen Pines Hospital, Oradell. The secretary was instructed to so notify the members.

Following applicants were elected to membership: DRS. DANIEL L. GOLDSTEIN, Hackensack; SAMUEL A. WEISS, Teaneck; NATHAN W. NEMIROFF, Oradell; MARGARET A. CLARK, Woodcliff Lake.

Speaker of the evening was DR. C. T. RHOADS, Professor of Pathology, Cornell University Medical College, who spoke on *Recent Advances in Cancer Research*. He reviewed the early laboratory experiments in which carcinoma was experimentally induced in rats by the ingestion of a dye. It was found that diets high in riboflavin and cysteine would protect the rat against carcinoma when fed this dye. This was one of the early attempts at protecting animal tissue against carcinoma by chemical means. The speaker divided his approach to the problem into chemotherapeutic attack on cancer and the rôle of the hormones in cancer production.

During the last war the Chemical Warfare Department of the Army had developed a mustard compound called H.N.2, which produced a leucopenia. When doses were fractionated it destroyed specific white cells in the blood. Given intravenously, it destroyed lymphosarcoma in animals and humans. Hodgkin's disease was successfully treated in 75 patients, or at least, long remissions were induced. This compound produces all the effects of deep x-ray therapy.

The speaker expressed great hope for the future of chemotherapy in the treatment of cancer. He answered several queries from the floor and was well received for one of the finest lectures ever presented before the Society.

The meeting adjourned to collation at 11 p. m.

CAMDEN COUNTY

Joseph C. Lovett, M.D., Reporter

Regular meeting of the *Camden County Medical Society* was held at the Camden City Dispensary on February 5, 1946, with Dr. Henry B. Decker, President, presiding. There were fifty members present.

Speaker of the evening, Dr. Louis H. Clerf, Professor of Laryngology and Bronchoscopy at Jefferson Medical College, was introduced to the Society by Dr. Kline. He spoke on the *Clinical Significance of Certain Respiratory Symptoms.* Those discussed were wheeze, hemoptysis, cough and hoarseness. The discussion was illustrated by slides showing the causes and symptoms. Colored motion pictures were shown of the normal larynx at rest and in action in the living person and also some of the diseases of the larynx. The talk was discussed by Dr. Kline. Dr. Shipman moved that Dr. Clerf be given the thanks of the Society. This was unanimously passed.

Application of Dr. Joseph Newmeyer to transfer his membership from Burlington County to Camden County Society was read.

Honorary membership was granted to Dr. Clara Horner Rodger and active membership to Dr. James Harbeson, III. Dr. A. Joseph Hughes was approved by the Membership Committee and Censors.

Dr. Norman Scott, Medical Director of the Medical Service Administration of New Jersey, presented a plan for the care of veterans and reviewed the proposed fee schedule. The Veterans Administration will decide what cases are "service connected". These will be referred through the Medical Service Administration to local participating physicians for treatment. The plan was discussed by Drs. Shipman, Jack, Sharp, Lewis, Kain and Ebner. Dr. Jack moved that our Society accept the plan since it is sponsored by the State Society.

Dr. Martin Collier read a memorial to Dr. Orris W. Saunders, our Past President, who died January 13, 1946.

Members who had recently returned from service were welcomed by the Society. Those present were Drs. Tatem, Gilbert, Grenhart and Albert Shafer.

CAPE MAY COUNTY

C. W. Way, M.D., Reporter

Regular meeting of the *Cape May County Medical Society* was held at Fred's Restaurant, Cape May Court House, February 26, 1946, at 9 p. m. Present were: Drs. Brooks, Samuel Hughes, Harold Hughes, Moon, Yingling, Pettit, Cameron, Cooper, Cohen, Hornstine, Fath, Crowe, Eisenhower, Markowitz and Way. The president, Dr. G. M. Brooks, presided. Dr. Paul Cameron presented the State Society's plan for the medical care of veterans. The medical fees would be collected for the participating doctors by the Medical Service Administration of New Jersey, of which organization Dr. Norman M. Scott is the Medical Director. Dr. Cameron stated that the Medical Service Administration is a non-profit organization formed under the guidance of the State Medical Society to operate the Society's plan for prepaid medical care. He stated that the fee schedule was approved by The Medical Society. Cape May County physicians will be paid for their work by the Medical Service Administration and they in return will be paid by the Veterans Administration. Dr. Cameron stated that there are more than 142,000 veterans in New Jersey waiting for medical examination on pension applications and that the number was increasing daily. He pointed out the necessity of every physician accepting this plan, unless he wanted to be paid for his work on the old veterans' fee schedule which is considerably less than the present one. He urged every physician to fill out his postcard, sign and mail.

It was announced that the 180th Annual Meeting of the New Jersey State Medical Society would be held at the Claridge Hotel, Atlantic City, N. J., May 21, 22, 23, and every member was urged to be present at the first post-war annual meeting.

The president appointed a new program committee consisting of Drs. C. W. Way, Chairman, Sea Isle City; Aldrich C. Crowe, Ocean City, and J. S. D. Eisenhower, Wildwood. It was voted to hold the next regular meeting the first Tuesday in May to elect new officers before the annual meeting of the State Medical Society.

Supper was served at midnight.

CUMBERLAND COUNTY

Norman W. Henry, M.D., Reporter

Doctors of the *Cumberland County Medical Society* were guests of Kimble Glass Company of Vineland on February 12, 1946. Thirty-four members including several returned service men were in attendance. A guided tour of the plant was made.

Much scientific glassware is made at Kimble Glass Company including graduates, fermentation tubes, ampules, blood pipettes, distilling flasks and others. The blowing of glass taken from the hot ovens, twirling the molten mass at the end of blow pipes, shaping and molding it into various products was extremely interesting. The machinery was close to human skill with untold accuracy in marking the waxed surface of graduates, pipettes, etc. The lamp room with its skilled workers was intriguing in its complexity.

Following the tour a regular meeting of the society was held in the Kimco Club Room of the plant. Dr. G. N. Thomas presided and called on the secretary, Dr. F. M. Ramsey, for the minutes of the last meeting and the executive meeting. These were approved as read. A committee was appointed to be known as the Cumberland County Historical Society Committee. Its function is to be that of securing a summary of the society from its earlier days to the present.

A resolution was passed authorizing a special liability insurance to cover the society and members for libel.

Dr. Charles W. Wilson suggested that a special meeting be held for the benefit of the returning physicians. This is to be a social "get-together" in which the returned physicians may each relate their experiences while in service.

Following the business meeting Mr. Joseph F. Greene, Research Director at Kimble Glass Company, introduced Dr. Dudley Smith, chemist, who discussed the *Chemical Durability of Glass* with

special reference to contents and sterility. MR. JAMES J. MORAN briefly talked about the accuracy of graduated glassware.

Following the scientific discussion, a steak dinner was held for the society in the Kimco Luncheonette.

ESSEX COUNTY

Anthony Ambrose, M.D., Reporter

The Council of the *Essex County Medical Society* met on January 22. A resolution was passed urging Medical Service Administration to attempt to effect an increase to $3 and $5 for day night calls for physicians who attended the indigent sick . DR. CRECCA reported for the Blood Bank Committee that a meeting was held with representatives of the Red Cross and that that organization exhibited reluctance to join with any agency which made a charge for services. On request of DR. MURRAY, the Council approved the survey of child care facilities now being made. Reporting for the Veterans Care Committee, DR. HURFF recommended that the plan for the care of veterans be coördinated with the hospital plan, and a motion was passed urging the Hospital Association to expedite the signing of contracts for the local hospitalization of veterans. DR. ANTONIUS reported that the state had launched a program looking for the provision of 40 to 50 beds for a child heart clinic.

DR. GREIFINGER reported for the Medico-Legal Testimony Committee and announced a recommendation that physicians who come to the Compensation Bureau on only occasional cases receive maximum fees, the purpose being to implement Labor Commissioner Harper's wish that more physicians undertake to give testimony before the Bureau. The Secretary read a letter from the Chairman of the Finance Committee of The Medical Society of New Jersey with reference to the remission of a year's dues to returning veterans. The decision of the state committee was that such action was not retroactive.

The Council voted to send our delegates to the Annual Meeting of the State Society uninstructed as to voting for candidates for state office unless Essex County had a candidate.

The Council passed the following resolution: *We do not approve recognition of graduates of other than Class A medical schools, whether they be veterans or not, for the reason that this would violate provisions of the Medical Practice Act and lower our state's medical standards.*

The "Model Expert Testimony Act" was endorsed in principle by the Council. On request of DR. H. S. MARTLAND, made through DR. T. W. HARVEY, Council voted to engage an attorney for the incorporation of the Plasma Bank, nomination of the attorney to be made by the President of the Essex County Medical Society.

HUDSON COUNTY

Harry J. Perlberg, M.D., Reporter

Regular meeting of the *Hudson County Medical Society* was held January 8, 1946, at the Jersey City Masonic Club. Following physicians were elected to membership: Dr. Joseph L. Corless, Dr. Alexander S. Horowitz, Dr. William A. Lee, Dr. Samuel V. Richmond, Dr. Solomon Silvera and Dr. Pasquale M. Vespignani. The Board of Censors approved Dr. Richard Good for reinstatement. The program opened with a talk by DR. R. C. FAGLEY, Chief Medical Officer, Veterans Administration, New Jersey Region, who urged members of the Society, both general practitioners and specialists, to notify the Veterans Administration promptly of their willingness to become designated, fee-basis physicians to care for returned wounded and physically unfit veterans of World Wars I and II. He predicted that the present scale of fees, for both general and special services, will be raised.

Dr. Fagley emphasized a pressing need for full-time general medical men to work under his supervision in the Newark office. Authorized to appoint thirty-five full-time physicians immediately, he said, only fourteen have been appointed. Present basic salary for full-time physicians is $4,300 per year (with a probable increase of 12 per cent) on a forty-hour, five-day week basis. Present requirements, however, call for a minimum of forty-eight hours, or $792.00 additional. Night work is also available.

Only a very limited number of part-time physicians are required, the quota being about filled at the present time. Dr. Fagley hoped that each county medical society will assume responsibility for the operation of the plan in the area.

DR. NORMAN M. SCOTT emphasized the urgent need of men to act as designated, fee-basis physicians and the present deplorable lack of medical examination centers. Dr. Scott then explained a proposed interim plan sponsored by Medical Service Administration and operated on an insurance basis. This he described as a "community service", designed to operate until a final plan has been adopted.

Following discussion, DR. LONDRIGAN offered the facilities of St. Mary's Hospital in Hoboken as an examination center, and DR. EVANS (through Dr. Londrigan) offered the facilities of North Hudson Hospital.

DR. RUOFF, chairman of the Sub-Committee on Medical Care of the Veteran, moved that the temporary plan outlined by Dr. Scott be approved by the Society; and that the secretary send all members of the Society an explanatory letter, requesting at the same time that they fill out the two enclosed cards signifying their willingness to become designated physicians, mailing one to Dr. Fagley and the other to the office of the Society for record. This motion was seconded and carried.

A regular meeting of *Hudson County Medical Society* was held February 5, 1946, at the Masonic Club in Jersey City. It was called to order by the president, DR. H. H. TYNDALL, at 9:30 p. m. Minutes of the previous regular meeting of January 8 and the Executive Committee meeting of January 14 were approved as printed in the February *Bulletin*. The Secretary, DR. V. P. BUTLER, reported that 242 members of the Society have already signified their willingness to become designated physicians in connection with the proposed Veterans Administration

Plan. The following applicants were elected to membership: Dr. Edwin Mackowsky of Jersey City, Dr. Richard J. Lempke of Jersey City, Dr. Milton Manette of Union City and Dr. John J. Bedrick of Bayonne.

The following former members were reinstated: Dr. Herman C. Comora of West New York, Dr. Julius Heilbrunn of Jersey City and Dr. Meyer Smith of Jersey City.

At the scientific session, Dr. Reginald H. Smithwick, Professor of Surgery and Chairman of Department of Surgery, Boston University Medical School, and Surgeon-in-Chief of Massachusetts Memorial Hospital, spoke on his experiences with the study and surgical treatment of *Hypertensive Cardiovascular Disease.*

MIDDLESEX COUNTY

Arthur J. Barbano, M.D., Reporter

Regular monthly meeting of the *Middlesex County Medical Society* was held at Roosevelt Hospital, Metuchen, at 9 p.m., February 20, 1946, with the president, Dr. C. Howard Rothfuss, presiding. Minutes of the January meeting were read and approved.

On recommendation of the Ethics Committee, Dr. F. M. Hoffman, Chairman, following applicants were elected to Associate membership: Dr. Benjamin Merino of New Brunswick, Dr. Frank Romano of Plainfield and Dr. Ralph Siegel of Perth Amboy.

The following members, discharged from active military service, were reinstated to full membership status: Dr. Gerard Gessner of New Brunswick, Dr. C. E. Hesseltine of South Amboy, Dr. S. David Miller of New Brunswick, Dr. James J. Lucey of Perth Amboy, Dr. Sidney Tucker of Perth Amboy and Dr. S. Manlius Lazow of Matawan.

Dr. W. E. Sherman read the report of the Executive Council relative to the proposed bill to grant medical licenses to alumni of unapproved schools who had served as medical officers in the Army or Navy. The Council voted to disapprove the suggestion, feeling that it would lower the present high medical standards in New Jersey.

Dr. Fithian reported that a contract had been signed with the Veterans Administration for the care of veterans as outlined in the Plan of The Medical Society of New Jersey. The Plan now receives 8 per cent administrative cost as contrasted with 7 per cent previously proposed, and orthopedic fees were generally higher than in the early draft of the fee schedule.

Guest of the evening, Dr. Martin G. Vorhaus, Attending Physician, Hospital for Joint Diseases, New York City, was introduced by Dr. Rothfuss, and a concise and learned paper on *The Evaluation of Thiouracil in the Treatment of Hyperthyroidism* was enjoyed by the members.

MONMOUTH COUNTY

F. Lawton Hindle, M.D., Reporter

The first meeting of the new year of the *Monmouth County Medical Society* was held on January 23, 1946, at the Fitkin Memorial Hospital. The attendance, which exceeded 50, was the best turnout in years, and for the late-comers there was "standing-room only". Dr. Granville Jones, President, convened the meeting at 9:15 p.m., and suggested that the regular business session be deferred until after hearing from our guest speaker, Dr. William O. Wuester, director of the Department of Neoplastic Diseases of Elizabeth General Hospital, Elizabeth, N. J. Dr. William G. Herrman introduced Dr. Wuester to the Society members.

Dr. Wuester's subject was *Common Forms of Malignancy,* and his talk was accompanied by excellent lantern slides in color depicting the many and various lesions before and after treatment. Dr. Wuester pointed out clearly which cases should be treated surgically and which by x-ray or radium. He discussed briefly the surgical technic of plastic flap reconstruction of the face. The members are indebted to Dr. Wuester for his erudite talk, so admirably and clearly presented, and should be better prepared to advise their patients about neoplastic lesions. At the conclusion of the presentation, questions and an open discussion followed.

Dr. Jones welcomed the many old and new faces present, and expressed the hope that the increased attendance would continue throughout the year. Some of the more recently returned veterans were Drs. Clark, Wornoff, Goff, Edelson, Quirk, Fineberg and Tripp.

Dr. Jones announced that the State Society had refunded to the County Society funds comprising the dues paid by 42 members during the year of their military service. To determine the distribution of this money, Dr. Jones appointed a committee consisting of Dr. Featherstone, Chairman; Dr. Wilkins and Dr. Pingatore.

Dr. Jones reported that at the last meeting of the Executive Committee, it was voted to create a membership committee to initiate a drive for membership, and to this committee, the president appointed Dr. Blaisdell, Chairman; Dr. McDonnell and Dr. Wornoff.

The secretary read a list of applications for associate membership: Dr. William Koch, Asbury Park; Dr. Leo Rocco, Red Bank; Dr. Irving Graber, Belmar; Dr. Irving Baer, Red Bank; Dr. Elias E. Long, Red Bank; Dr. Robert McCurdy, Atlantic Highlands; Dr. Norman Nathanson, Long Branch.

Motion was made that these applicants be approved as a group for associate membership. Motion passed unanimously.

The secretary read a list of applications for full membership: Dr. Richard Demaree, West Long Branch; Dr. H. W. Booth, Spring Lake; Dr. Helen Jones, Asbury Park.

Motion was made that these applicants be approved as a group for full membership. Motion passed unanimously. The secretary stated that additional applications had been submitted, but that he had not yet received the biographic data from the American Medical Association and that as soon as they were received, these applications would be acted upon.

Next item was a change in the Constitution and By-Laws concerning associate memberships and transfer memberships. Following changes were unanimously approved: (1) That an associate membership was to be for the duration of one year, and

that the associate member be eligible for full membership at the end of one year. (2) That an application for transfer membership be acted upon at the next regular meeting instead of after 90 days as previously.

Dr. Jones reported on the State Plan for Veterans Care, and pointed out that DR. NORMAN M. SCOTT, Medical Director of Veterans Administration, had termed this plan "evolutionary" and not yet in its final form. Dr. Scott then reviewed the main features of the Monmouth County Plan for Veterans' Care for the benefit of new and recently returned physicians.

DR. WILLIAM G. HERRMAN announced that he and Dr. Jones were to present in Washington, D. C., to General Hawley the following fee schedule in regard to the Screening Clinics already established in Monmouth County:

1. $25 per clinic to the hospital where clinic is held.

2. $20 per physician for each clinic of 30 processed patients, or a maximum of 2½ hours' time.

3. If more time than 2½ hours is required or more than 30 patients present themselves at any one clinic, an additional clinic is to be established.

It was moved, seconded, and passed that this schedule be approved by the County Society before Drs. Herrman and Jones present same to General Hawley.

Dr. Jones reported that, inasmuch as a new telephone directory would not be published until July, the matter of acquainting the public with addresses and telephone numbers of returned doctors and new doctors was discussed at the last meeting of the Executive Committee. A plan was approved by the Executive Committee, to arrange for listings twice weekly in several of the county papers of the names, addresses and telephone numbers of new and returned doctors. Members desiring such a listing were asked to give their names to DR. DANIEL FEATHERSTONE.

N. J. NEUROPSYCHIATRIC ASSOCIATION

The February 27th meeting of the N. J. Neuropsychiatric Association was devoted to the problem of alcoholism. First speaker, MR. ALFRED DRISCOLL, New Jersey's Commissioner of Alcoholic Beverages, spoke of the State's interest in plans for the rehabilitation of the chronic alcoholic, and called on the medical profession for help in meeting this problem. Second speaker, DR. RAY J. MULLIN, Chief Police Surgeon, City of Newark, stressed the concept of alcoholism as a disease which can be treated in a person who is worth treating. Dr. Mullin urged physicians to arouse public interest to the point where no new hospitals would be built or expanded without adequate provision for the in-patient care of the alcoholic. Next speaker was PROFESSOR RILEY of the Sociology Department of Rutgers University, who reported on a survey of the treatment of chronic alcoholics by private practitioners. From his figures, it appeared that about 30,000 alcoholics were treated in New Jersey during 1945, and that 65 per cent of the state's practitioners had had professional contact with one or more alcoholics during the year. Most doctors depended on sedation or vitamin therapy, only one in seven making any attempt to use psychotherapy and fewer than 10 per cent using amphetamin. Final speaker was a member of *Alcoholics Anonymous*, who described the growth of his organization and asked for coöperation by New Jersey psychiatrists. DR. LEWIS H. LOESER, president of the Association, deplored the inadequate facilities for the housing of alcoholics in the general hospitals in the state.

SOCIETY OF SURGEONS

The 1946 Annual Meeting of the *Society of Surgeons of New Jersey* was held at the Country Club, Plainfield, N. J., on January 30. The scientific session was devoted to short papers by Dr. William B. Fort (on *Gynecology during the child-bearing period*), Dr. Paul Geary (on *Surgery in Chest Disease*), by Dr. N. B. Stanton (on *Anastomosis of the Large Bowel*) and by Dr. Thomas M. Morris (on *Urologic Accidents During Abdominal Surgery*). This was followed by a symposium on *Treatment of Battle Casualties* in which Dr. Spencer Snedecor, Dr. Charles A. Hoffman and Dr. Charles T. Steffens were the participants. At the conclusion of the scientific session, there was a business meeting at which DR. JOSEPH H. ORAM of Paterson was elected president. DR. CHRISTOPHER BROKAW of Elizabeth, treasurer, and DRS. H. W. NAFEY of New Brunswick and R. A. SCHAAF of Newark were elected vice-presidents. DR. WALTER B. MOUNT of Montclair was re-elected secretary. Highspot of the meeting was a talk by MAJOR GENERAL NORMAN KIRK, Surgeon General, U. S. Army, entitled *"The Remaining Task"*, which was delivered at the close of the annual banquet.

THE OLD DAYS ARE ALWAYS THE GOOD ones . . . in fantasy. A patient, protesting the "high cost of medical care" remembers that grandpa got medical service at the cost of a dollar a call. Yes, but what grandpa got was a pulse-count and a three-ounce bottle of a "bitter tonic". Which wasn't worth more than a dollar a call. Today's patient gets an examination that uses modern, expensive equipment; receives drugs or biologicals made potent by costly research and costly preparation. The additional expense has to be reflected in the doctor's bill. You can't beat arithmetic.

THE GROWING MENACE OF THE RAT (THE four-legged kind) is stressed in James N. Miller's recent report to Hygeia. The rat, he pointed out, is the world's most notorious disease carrier, with the possible exception of the flea. The rat carries typhus fever, bubonic plague, certain forms of jaundice, mange, tapeworm, and possibly hoof-and-mouth disease, encephalitis and poliomyelitis. Rat-bite fever has its stronghold in the South, but the disease has been slowly climbing northward. At least two cases were reported in Washington, D. C., in 1941.

WOMAN'S AUXILIARY

WHY AN AUXILIARY?

MRS. WILLIAM E. DODD, President

Dear Doctor and Doctor's Wife:

I am writing to you who do not know why the Woman's Auxiliary to the New Jersey Medical Society was organized and to dispute the statement I have heard so many times lately, "There is no need for an Auxiliary."

When the New Jersey Medical Society was organized in 1776 I doubt whether many doctors' wives accompanied their husbands to their meetings. But as the years passed and transportation and hotel accommodations improved, it was a splendid vacation for the doctor's wife to meet other wives while their husbands discussed the discoveries of medicine. As was natural, these women lost interest in the exchange of new recipes and hand work and awakened to the need of more interest in matters pertaining to their husbands' profession.

To promote better feeling among physicians' families the Woman's Auxiliary was organized in 1927 with the promise to assist the Medical Society in whatever way they could. From the twenty-one counties in the state, nineteen auxiliaries were organized. Only fourteen of the original number remain. It did seem to be more or less a social organization in the beginnng but today wth nine hundred members the aid which can be given the Medical Society is of no little consideration.

Through regular attendance at meetings a well informed Auxiliary member is able to discuss the good and bad points of current legislative bills affecting the welfare of the people of this state and by personal contact and letter influence the action of our legislative representatives. She takes an active part in arousing the interest of the public in health education. She does not give health talks but she is able to procure the proper speaker for the occasion. She is interested in local or county philanthropies sponsored by the Auxiliary. She acquires a better understanding of all the responsibilities her husband carries. As Dr. Rock Sleyster, Past-President of the American Medical Association, in his address to the Woman's Auxiliary in 1939, said, "And as you stand hand in hand and look back over the years, there will be the joy and satisfaction of hearing him say—'You were my partner—it was possible only because of you.'"

It is working together for a common cause which has wrought wonders in this war-torn world of today. Together we can advance the aims and purposes for which we exist. If you are not now an Auxilairy member, join your County Auxiliary. If no Auxiliary exists in your County, apply to the County Medical Society for approval to organize or apply to me for membership-at-large. Organization Chairman, Mrs. J. Howard Hornberger of Roebling, New Jersey, will be very happy to assist in establishing an Auxiliary in your county.

ARCHIVES AND HISTORY

MRS. C. CHESTER CHIANESE, Chairman

To insure a complete history of the Woman's Auxiliary to The Medical Society of New Jersey for the year 1945-1946, it is necessary that each county historian file a report with the state historian. The following suggestions will make simple the task and produce concise records:

1. Names of officers.
2. Number of meetings.
3. Increase in membership and reason.
4. Specific work assigned by your County Society.
5. Philanthropic endeavors and amount raised.
6. Social activities and purpose.
7. Work done by various committees.
   - (a) Art, hobbies, Medical Histories.
   - (b) Bulletin and Hygeia.
   - (c) History.
   - (d) Legislation.
   - (e) Post War Medical Plan.
   - (f) Programs—Speakers' Bureau.
   - (g) Public Relations.
   - (h) Publicity.
   - (i) Widows and Orphans.

8. Affix the necrology of the year to this document for the Memorial Book. Save clippings and notices as evidence.

Histories should be dated and signed by the President and Historian. Prepare two copies; keep one for the County Archives and forward the other to the State Historian. This office will in turn compile the annual Auxiliary History which will be stored permanently in the State Archives.

"This learned I from the shadow of a tree
That to and fro did sway upon a wall;
Our shadow selves, our influence, may fall
Where we can never be."

KNOW YOUR COUNTY AUXILIARY PRESIDENTS

Passaic County

MRS. JOSEPH E. MOTT



Eileen C. Mott was born July 1, 1910, in the town of Norfolk, Connecticut, the only daughter of Michael and Ellen McManus. She moved with her parents to Paterson, New Jersey, at the age of five, where she attended St. Bonaventure's School, Central High School and Paterson Teachers' College. From 1930 to 1935 she taught in the Paterson school system, leaving to be married on June 5, 1935, to Dr. Joseph E. Mott, now a Lieutenant Commander in the service of his country. At present Dr. Mott is stationed in Japan. Until her husband's return, Mrs. Mott and their son Robert, age six, are living with her parents.

Mrs. Mott joined the Auxiliary in October, 1935, has been Hygeia Chairman, Chairman of Press and Publicity for several years, Program Chairman, Social Chairman, and President for the past three years, the longest term ever held by one President of the Passaic County Auxiliary.

We sincerely hope Dr. Mott will soon return to his family.

Warren County

MRS. FLOYD A. SHIMER



Della M. Steele Shimer was born in Everett, Bedford County, Pennsylvania, the daughter of Rev. and Mrs. William M. Steele. She was graduated from Everett High School and Everett Summer Normal School. For a number of years she was associated with the Everett Press and later with the Chemical Publishing Co. of Easton, Pa.

In 1932 she was married to Dr. Floyd A. Shimer of Phillipsburg, N. J.

She has been a member of the Board of Women Managers of Warren Hospital since 1933 and has served two years as President of that organization. She organized the Junior Auxiliary of Warren Hospital in 1939 and has served as their Senior Adviser since its organization.

She helped organize the Woman's Auxiliary to the Warren County Medical Society and served as Treasurer until 1940, since which time she has served as President.

In 1943 Mrs. Shimer was Second Vice-President and Bulletin Chairman for the Woman's Auxiliary to the New Jersey Medical Society.

She is a member of Delaware Chapter No. 50, Order of the Eastern Star of New Jersey.

AUXILIARY REPORTS

Atlantic County

Mrs. Samuel Salasin, Chairman of Publicity

Plans for a health program meeting were discussed at a luncheon and meeting of the *Woman's Auxiliary to the Atlantic County Medical Society* held Friday afternoon at the Chelsea Hotel. Mrs. Robert A. Bradley presided at the business meeting.

Mrs. David B. Allman, chairman of public relations, announced that the health program will take place at the Ambassador Hotel on March 8 at 2 o'clock. Speakers for the affair include Mrs. Haines Lippincott, of Camden, N. J., who will discuss *"Cancer Control"* and show motion pictures on the subject; Dr. Elinor Langton, who will speak on *"Mental Hygiene,"* and a third speaker whose subject will be *"Juvenile Delinquency"*.

The meeting will be open to the general public and invitations have been extended to all local organizations.

Mrs. Bradley gave an interesting account of the recent dedicatory services for past president of the State Auxiliary held in Trenton.

Mrs. Daniel C. Reyner was chairman of the committee on arrangements for the luncheon.

Camden County

Mrs. Thomas H. McGlade, Chairman of Publicity

The February meeting of the *Woman's Auxiliary to the Camden County Medical Society* was held at the home of Mrs. A. Haines Lippincott, 406 Cooper Street, Camden, on February 5.

Dr. Norman M. Scott was guest speaker and his

subject was the Medical-Surgical Plan of New Jersey.

Mrs. William E. Dodd, State President, of Beach Haven, attended the meeting.

The following officers were elected for the coming year: *President,* Mrs. A. Lincoln Sherk; *President-Elect,* Mrs. A. Gomersall Pratt; *First Vice-President,* Mrs. Harold D. Barnshaw; *Second Vice-President,* Mrs. Gerald Husted; *Third Vice-President,* Mrs. A. M. K. Maldeis; *Recording Secretary,* Mrs. Harold K. Eynon; *Corresponding Secretary,* Mrs. John Rudolph; *Treasurer,* Mrs. Banks Baker.

Delegates chosen to attend the State Convention in May were: Mrs. A. Lincoln Sherk, Mrs. Kenneth Athey, Mrs. Joseph E. Roberts, Mrs. Maldeis, Mrs. A. Haines Lippincott, Mrs. Thomas Lewis and Mrs. Reuben L. Sharp; as Alternates, Mrs. Gerald Husted, Mrs. Henry B. Decker, Mrs. Harold D. Barnshaw, Mrs. John P. Brennan, Mrs. Lester Wilson, Mrs. William Braun and Mrs. Arthur Casselman.

Essex County

Mrs. Rocco Marra, Chairman of Publicity

The *Woman's Auxiliary to the Essex County Medical Society* held their membership meeting on Monday, January 28, 1946, at 1 o'clock at the Academy of Medicine, introducing new members to the Auxiliary.

An outline of the purposes and organizations of the Auxiliary was given by Mrs. H. Roy Van Ness of Newark. Mrs. Jack Schmuckler of South Orange, a new member, gave a review of *The Egg and I,* by Betty McDonald. The speakers were introduced by Mrs. Daniel Kavanaugh of Newark, Vice-President, who read a word picture of *A Doctor's Wife,* written by a doctor.

A nominating committee was appointed to prepare a ticket for the Spring election. Mrs. Lodovico Mancusi-Ungaro of Newark, a former president, was elected chairman. Other members are: Mrs. Frank J. McCauley, Glen Ridge; Mrs. Morton M. Stern, Newark; Mrs. Francis Just, Newark, and Mrs. Schmuckler.

The President, Mrs. S. Bernard Kaplan of East Orange, presided at a business session where officers and chairmen gave reports. The meeting closed with a tea.

Gloucester County

Mrs. C. A. Bowersox, Press and Publicity Chairman

The *Woman's Auxiliary to the Gloucester County Medical Society* was entertained at a luncheon at the home of Mrs. William Pedrick, 11 West Street, Glassboro, on Thursday, January 24, at 1 p. m. Eighteen members and two guests were present. Three new members, Mrs. Kate Brewer, Mrs. David Brewer, Jr., of Woodbury, and Mrs. John J. Laurusonis of Gibbstown were welcomed into the Auxiliary by the President, Mrs. Fred J. Faux.

Following the luncheon, the regular business meeting was held with Mrs. Faux presiding. Plans were discussed for the February luncheon in Pitman and the March public relations meeting.

The nominating committee selected includes Mrs. Paul M. Pegau of Woodbury, Mrs. William Harris of Mullica Hill and Mrs. Guy Campo of Westville.

Mrs. Faux appointed Mrs. Ralph Hollinshed of Westville and Mrs. Chester I. Ulmer of Gibbstown to make a study of the local Auxiliary Constitution.

A luncheon and business meeting was held at the Pitman Hotel, Pitman, N. J., February 21 by the *Woman's Auxiliary to the Gloucester County Medical Society.* Mrs. Frederick Wandall of Clayton presented Mrs. Fred Gravino, guest pianist, and Miss Jean Brooks, soprano soloist, both of Pitman.

Mrs. William E. Dodd of Beach Haven, State Auxiliary President, the guest of honor, was introduced by Mrs. Fred Faux of Woodbury. Mrs. Dodd spoke on the history of the State Auxiliary, paying tribute to former presidents, and spoke of our duties to our husbands in the medical profession. Mrs. Dodd stated that we as members of the Auxiliary can be of much value toward helping free and non-political medical practice.

Of interest to all members was a legislative letter read by Mrs. C. I. Ulmer of Gibbstown.

There were 21 members present, including Mrs. S. Thomas Campo of Westville, a new member.

Hudson County

Mrs. Sidney Chayes, Chairman of Publicty

A regular monthly meeting of the *Woman's Auxiliary to the Hudson County Medical Society* was held at the Y. W. C. A. building in Jersey City on Monday, February 4, 1946. Mrs. Edward Murphy, President of the Auxiliary, presided.

Plans were completed for a welcome home dessert bridge to be held February 18 to honor the wives of the doctors who served in the armed forces.

Mrs. Alexander Ruoff, Chairman of Public Relations, announced that the Auxiliary is sponsoring an essay contest for all seniors in Hudson County high schools. Subject of the contest is: *The Advance in Medicine Resulting from the War.* A Victory Bond will be awarded the winner at the Reciprocity Meeting on March 4, 1946.

The Program Chairman, Mrs. William Gleason, presented Miss Martha Williard, a representative of a well-known beauty salon, who spoke on health and beauty through body building and good grooming.

Tea was served after the program.

Mercer County

Mrs. C. Chester Chianese, Publicity Chairman

The *Woman's Auxiliary to the Mercer County Medical Society* held a regular meeting at the Executive Office of The Medical Society of New Jersey on February 5th, 1946. Mrs. H. Donald Cowlbeck, President, presided.

An invitation from Dean Frederick Adams was read. Members were urged to attend a series of lectures on Intercultural Relations under the auspices of the Trenton Committee for Unity, the Council of Social Agencies, the Y. W. C. A., and the League of Women Voters.

A letter was read from Dr. S. William Kalb, Nutrition Representative, stating that the Committee on Adult Diseases of The Medical Society of New Jersey deemed it important that a symposium on nutrition be held in our county and sponsored by the Auxiliary. It was decided to plan a Public Rela-

tions meeting and tea at the Medical Offices on Tuesday, April 9th, two to five o'clock. Speakers for the round-table discussion and exhibit will be supplied by the Nutrition Committee. The committee to assist Mrs. Thomas V. Murto, Public Relations Chairman, was appointed. They are Mrs. Kustrup, Mrs. Finegan, Mrs. Chianese, Mrs. Cohan, Mrs. Ivins and Mrs. Purcell.

Reports were submitted by the following committees: Medical Histories, Widows and Orphans, and the Nurse Scholarship Award.

Mrs. Chianese, who represented the Auxiliary at a meeting and tea of the Women's Aides at the home of Mary Roebling, gave an interesting account of the Christmas party held at the Donnelly Memorial Hospital on December 20th, 1945, for the benefit of the residents and patients of that institution. With jolly Santa leading the way the assembled aides assisted in the distribution of refreshments and gifts. Elaborate entertainment by professionals brought laughter and sunshine reaching deep into the hearts of those less fortunate. This annual program is indeed a most worthy one.

The members expressed their desire to resume the annual Dinner-Dance and Card Party in conjunction with the Medical Society. Definite decision will be made at a later date.

Following the meeting a social hour was enjoyed. Tea was served with Mrs. Kustrup and Mrs. Finegan as our charming hostesses.

Middlesex County

Mrs. Norman Rosenberg, Chairman of Publicity

A regular meeting of the *Woman's Auxiliary to the Middlesex County Medical Society* was held on February 21, 1946. The Auxiliary was informed of the clipping project for cutting out the *Health Hints* released by the Medical Society and pledged cooperation in this effort to determine the extent to which Middlesex County newspapers were using these releases.

The Auxiliary also voted to assist in the collection of medical equipment for the use of gallant physicians of The Netherlands who were stripped of all medical supplies when the Nazis invaded their country.

Next meeting of the Auxiliary will be held on March 20 at the home of Mrs. Samuel Berkow in Perth Amboy and will consist of a business session followed by a card party.

Passaic County

Mrs. Irving Silverman, Chairman of Publicity

The *Woman's Auxiliary to the Passaic County Medical Society* met on January 2, 1946, at the home of Mrs. Richard J. McDonald, Paterson, N. J. Mrs. Joseph E. Mott, President, presided at the business meeting, which was well attended.

After the report of the Secretary, Mrs. Earl Warren, committee chairmen reported for their groups as follows: Mrs. A. M. Schultz for camp and hospital; Mrs. McDonald for cancer bandages; Mrs. I. R. Hayman for arts, hobbies and medical histories; Mrs. Richard White for legislation; Mrs. A. M. Mineve for Bulletin; Mrs. Irving Silverman for press and publicity.

The following new members were graciously welcomed by the President: Mrs. Bernard Alprin, Mrs. Theodore Pollack, Mrs. Edward Ehrenfeld, Mrs. Max Magnes, Mrs. Marvin Cohen, Mrs. Philip Opper and Mrs. Joseph Polizzotti.

Mrs. Mott thanked Mrs. T. Vincent Connolly and Mrs. M. S. Joelson for their splendid work which made the recent card party a social and a financial success. Following this, Mrs. Mott reported on the January Executive Board Meeting held in Trenton January 10, 1946, which she and Mrs. McDonald had attended as representatives of the Passaic County Auxiliary.

Following the business meeting, the President turned the meeting over to Mrs. Albert Markel, program chairman, who had arranged an excellent program of entertainment.

The meeting closed with a membership tea given by the hostess in honor of the new members who had joined the Auxiliary since last January.

Warren County

Mrs. Herman Baldauf, Chairman of Publicity

The *Woman's Auxiliary to the Warren County Medical Society* met at the Elks' Home in Phillipsburg on Tuesday, January 22, 1946, at 10:30 a. m. with Mrs. F. A. Shimer, President, presiding. A report of the Executive Board meeting held in Trenton Monday, January 14, 1946, was given by Mrs. William Varney.

Following the business meeting luncheon was served to the Auxiliary members and to the doctors of the County Medical Society.

The monthly meeting of the *Woman's Auxiliary to the Warren County Medical Society* was held Friday, February 18, 1946. It was a luncheon meeting held at Morrie's Acres. Mrs. F. A. Shimer, president, presided.

Mrs. Charles Potter, Washington; Mrs. Russell B. Stone and Mrs. Walter Boquist, Phillipsburg, were elected to the Nominating Committee.

Plans for a Dessert Bridge to be held in the Woman's Club Room of the Bank Building of Washington, New Jersey, Saturday, March 16, 1946, were completed. Mrs. William Varney, Mrs. Charles Potter and Mrs. Mary Hackett were chosen to act as co-chairmen of the affair.

The Auxiliary discussed the solicitation of second-hand medical equipment to be sent to physicians in the Netherlands.

Mrs. Joseph Humbert of Stewartsville was welcomed at the meeting after an absence of several years.

PHILADELPHIA HEALTH INSTITUTE

Invitation has been extended to all members of the Auxiliary to The Medical Society of New Jersey to attend the Health Institute of the Woman's Auxiliary to the Philadelphia Medical Society on Tuesday, April 9, 1946, at the Medical Society's building, 21st and Spruce Streets, Philadelphia, at 10:30 a. m.

BOOK REVIEWS

Manual of Surgical Anatomy. Prepared under the auspices of the Committee on Surgery of the Division of Medical Sciences of the National Research Council. By Tom Jones and W. C. Shepard. Pp. 195 with 267 illustrations on 138 figures, 153 in color. Phila. & London, W. B. Saunders Co. 1945. **$5.00.**

Tom Jones and W. C. Shepard have, in conjunction with the publishers, produced an excellent *Manual of Surgical Anatomy* to which is appended a fairly complete explanatory index which serves as both an index and a sort of text.

In addition to the usual depictions of various areas of the body the authors have recognized the increasing importance of the autonomic nervous system by including excellent illustrations of the location of the various ganglia and ganglionated chains and the approaches thereto by injection and by surgery. These illustrations are a welcome addition.

The increasing importance of thoracic surgery has been recognized and there are several pages of excellent illustrations on thoracotomy and exposure of the hilar structures of the lungs.

The book is useful and important not only as a military manual but also as an index reference book for the general physician. C. ABBOTT BELING, M.D.

Men Without Guns. By DeWitt Mackenzie. Descriptive captions by Major Clarence Worden. Pp. 47 of text, illustrated with 137 plates from the Abbott collection of paintings owned by the United States Government. Philadelphia, Blakiston Co. 1945. $5.00.

This is a record of the work of the Army Medical Department in the war. The text is by a member of the Associated Press who was a war correspondent in World War I and a war analyst during World War II in Africa, Europe, Burma, China and the Pacific fronts. He saw the Army Medical Department in action and gives a graphic account of the men who fought without guns to save human life rather than destroy it.

A dozen American artists visited these war theaters and braved perils and hardships to make a notable series of historical paintings, now the property of the United States Government, and reproduced in this volume.

In the foreword, Major General Norman T. Kirk, The Surgeon General, states that "unequivocally and without fear of contradiction, I say with pride and reverence that one of the greatest contributions to victory has been made by the doctors, nurses and enlisted men of the Army Medical Department."

This is a living account of the *Men without Guns* and as such it produces a contemporary record of extraordinary interest and future archival value.

CAROLYN VALENTINE, B.S.

Bacillary Dysentery, Colitis and Enteritis. By Joseph Felsen, B.A., M.D. Pp. 618, illustrated. Philadelphia & London, W. B. Saunders Company. 1945. $6.00.

For many years Dr. Felsen has been an active advocate of the importance of the study of bacillary dysentery. In the present volume he has embodied all of his many contributions to the subject.

The first part of the book is an exhaustive dissertation on acute bacillary dysentery. He emphasizes the protean nature of the disease and the importance of differential diagnosis from disorders which it may simulate. This portion ends with a complete resume of treatment.

Part 2 concerns chronic ulcerative colitis, chronic bacillary dysentery and chronic distal ileitis and enteritis. Here Dr. Felsen endeavors to show that all these diseases have a common origin, that they are the sequelae of acute bacillary dysentery. In fact, he emphasizes that they are a complication of chronic bacillary dysentery.

The third part, the appendix, contains serologic tests for the identification of the various strains of bacillary dysentery and will be of great value to the laboratory technician.

Of outstanding merit in the book is the complete outline of treatment given for chronic ulcerative colitis and its complications.

Dr. Felsen has labored through the years to prove his premise, and has been instrumental in the formation of the International and Pan-American Dysentery Register.

In a relatively small monograph the author has included numerous charts, graphs and x-ray reproductions in a pleasing and easily read style. It will furnish the general practitioner as well as the specialist with clear and concise information on the entire subject of bacillary dysentery, colitis and enteritis. J. GERENDASY, M.D.

General and Plastic Surgery with Emphasis on War Injuries. By J. Eastman Sheehan, M.D. Pp. 345, illustrated. New York, Paul B. Hoeber, Inc. Medical Book Department of Harper & Bros. 1945. $6.75.

Sheehan's new book, *General and Plastic Surgery*, is a plastic surgical text in which an attempt is made to emphasize the importance of utilizing plastic procedures for the correction of many types of general surgical problems. There is considerable emphasis on war injuries with chapters devoted to such subjects as blast injuries, control of infection, wounds of the cranium and spinal cord, anesthesia, and wounds of the abdomen and pelvis.

The chapter on standard operations for repair describes various surgical procedures applicable to congenital and acquired deformities of the face and jaws. This is clearly presented and contains many excellent diagrammatic illustrations.

The book should be useful for the general surgeon in solving occasional plastic problems in various regions of the body. LYNDON A. PEER, M.D.

Facial Prosthesis. By Arthur H. Bulbulian, M.S., D.D.S., F.A.C.D. Pp. 241, with 202 illustrations. Philadelphia & London, W. B. Saunders Company. 1945. $5.00.

Although plastic surgeons per se are not inclined to make prosthetic devices, they should, however, be thoroughly familiar with the principle involved in this subdivision of dentistry.

There is a great difference in opinion as to whether a latex ear should be worn or whether an attempt should be made to reconstruct the auricle. Disadvantages of the latex method are that it must be cemented on each day, the edges fray out and the color may be unsatisfactory and fade in a comparatively short time, thus necessitating the construction of a new ear. On the other hand, such prostheses are at times a very excellent expedient for bridging over the gap from the time of destructive operation on an ear, nose, etc., until the plastic operation may be attempted.

Bulbulian has very thoroughly described these various procedures in detail and he further clarifies the text with excellent photographs and drawings.

The chapters are nicely arranged in that one is devoted to the reconstruction of the nose, another to the ear, eye, and so forth. The chapter, *Plastics in Facial Prosthetics,* is well covered; but the whole field of plastics is undergoing development and in a very short time, many new discoveries may make this chapter obsolete.

Time may be well spent by the plastic surgeon in reading this book; for by doing so, he can familiarize himself with the vast possibilities in this field and better describe his needs to laboratory men constructing the prosthetic appliance.

LYNDON A. PEER, M.D.

Ageing and Degenerative Diseases. Ed. by Robert A. Moore. Biological Symposia, vol. XI. Pp. 242, illustrated. Lancaster, Pa., Jaques Cattell Press. 1945. $3.00.

In this excellent collection of studies, the major theme is arteriosclerosis, but there also are found discussions of endocrinology, anatomic and pathologic aspects of the ageing process, nutrition, and papers dealing with clinical aspects of the problem such as glucose tolerance and blood cholesterol levels in elderly patients. Stieglitz in his chapter on difficulties of diagnosis, stresses the "need for new methods for the quantitative evaluation of health", and believes that "it is time that there be a much more quantitative attitude of mind in connection with diagnosis" rather than the largely qualitative type of the past.

It is estimated that by 1980 we shall have a senescent population of about 14.4 per cent. Today, individuals over 65 make up only 7 per cent of the population.

Since the primary object of medical practice is to improve health, he urges a more closely focused interest upon the patient who has the disease rather than upon the disease process itself.

Kerr, in a brief but interesting correlation of clinical knowledge in the treatment of the degenerative diseases, says that "if we applied what is now known concerning the syndrome of obesity, postural defects, pulmonary emphysema and circulatory failure, we could prolong the useful life of this large group of subjects for from 5 to 10 years.

Other matter presented includes such widely different subjects as that rare disease known as *progeria,* "premature senility" (salient features: infantilism and senilism) and a review by Leo Loeb of cancer and the process of ageing.

CHARLES ENGLANDER, M.D.

Embryology of Behavior: The Beginnings of the Human Mind. By Arnold Gesell, M.D., Ph.D., Sc. D., in collaboration with Catherine S. Amatruda, M.D. Pp. 289, illustrated. New York, Harper & Brothers, Medical Book Department. 1945. $5.00.

In the first ten chapters of his book, Dr. Gesell demonstrates in great detail the beginnings of soma as well as psyche. He points out that individual life begins from the moment of fertilization of the ovum, and that an "extraordinary amount of behavior organization takes place in the ten lunar months which precede birth". Through a vast amount of well digested literature, he explains the development of the embryo and the structure and behavior of the fetus and the neonatal infant.

Development of the growth mechanism, of the motor system, the breathing behavior and muscle tone are illustrated with many diagrams and graphs. Electrotonic integration and its interrelationship to all living tissue is discussed in detail. A systematic study was made of a group of prematurely born infants.

Two chapters are devoted to the description of fetal development and its relation to subsequent physical and mental growth. Photographs depict the beginnings and the stages of transformation of behavior which takes place between the fetal age of twenty-eight weeks and later infancy.

This is a carefully written book which condenses much of the present day knowledge of human development and of the beginnings of behavior. It should be read with interest by any physician, and particularly by pediatricians, biologists, neurologists, medical students and those interested in child psychology.

ROSE D. BASS, M.D.

Diseases of the Nose, Throat and Ear. Edited by Chevalier Jackson, M.D., Sc.D., LL.D., F.A.C.S., and Chevalier L. Jackson, M.D., M.Sc., F.A.C.S., with the collaboration of 64 authorities. Pp. 844 with 934 illustrations on 581 figures including 18 plates in color. Phila. & London. W. B. Saunders. 1945. $10.00.

In this new text on the rapidly expanding field of otolaryngology, the Jacksons, father and son, have edited a comprehensive volume in a clear and orderly manner. Newer developments in traumatic and reconstructive surgery, allergy, physiology of the nose, and irradiation of hyperplastic lymphoid tissue in the nasopharynx have been described by authorities in these fields. The technic of lateral

transthyroid pharyngotomy for malignant disease is presented in detail by Dr. Henry B. Orton of New Jersey. Photographs of models are reproduced.

In the sections on the ear, current emphasis in constructive and preventive therapy is reflected in the chapters written by men who have recognized the importance of care at a time when deafness has not yet fully developed, and who have been writing productively on this subject for years.

The more advanced diseases of the ear and their complications are presented with the new developments in therapy such as the Lempert fenestration operation. Dr. Wells P. Eagleton of New Jersey has written the section on osteomyelitis of the skull. It is a compact presentation of osteomyelitis as it occurs in various portions of the head, emphasizing the anatomic and physiopathologic factors in the etiology of this disease.

The sections on the larynx, trachea, and esophagus are written for the most part by the editors, in their usual detailed, specific and satisfactory manner, and the choice of this volume as a general text is especially indicated for those who are particularly interested in this field. However, it presents all other aspects of otolaryngology clearly and in sufficient detail so that it may also be used with profit by student and general practitioner.

Louise Fischer, M.D.

Clinical Biochemistry. By Abraham Cantarow, M.D., and Max Trumper, Ph.D. 3d ed. Pp. 647 with 29 illustrations. Phila. & London, W. B. Saunders Company. 1945. $6.50.

Modern medicine cannot be satisfactorily interpreted nor a rational plan of treatment outlined without a comprehensive understanding of the biochemical changes in health and in disease. Drs. Trumper and Cantarow in their new edition of *Clinical Biochemistry* have offered such a correlation. With the rapid development of internal medicine along physiochemical and biochemical lines, this volume fills a necessary niche near any organized text dealing with the clinical pictures of sundry diseases.

The authors have attempted to keep pace with new developments and technics, stressing those which have definite clinical significance. Among the major additions are topics relating to insulin tolerance tests; ketosis tests for adrenal hypo and hyper function, sulphur metabolism; insulin diodrast and hippuran clearance studies in the evolution of glomerular and tabular function and renal blood flow. Cephalin-cholesterol and plasma prothrombosis tests of hepatic function, secretin tests in the study of pancreatic function and various new methods for the study of deficiency states. These are but a few among the many excellent and new types discussed. Controversial subjects have been presented in an impartial manner.

The last chapter, which outlines chemical abnormalities in various disorders, is exceedingly helpful. The sections on hepatic, renal and endocrine functions are complete and lucid. At no time have the authors lost sight of the clinical applications of various tests. The section on metabolism is replete with new ideas and interpretations. If there is any portion of the book open to criticism, it could be that dealing with water metabolism and base balance. Here, the authors are too sketchy and incomplete. However, this is far overshadowed by general thoroughness of the major portion of the volume.

With the ebb and flow of knowledge and advancement in the understanding of diseases, books like these must be constantly revised, and the authors are to be commended for their efforts to keep their text up-to-date. The modern clinician whose ideas on diseases are being constantly revised will profit by a careful perusal of this new edition of *Clinical Biochemistry*. Herbert Greenfield, M.D.

BOOKS RECEIVED

Hypnoanalysis. By Lewis R. Wolberg, M.D. Foreword by A. Kardiner, M.D. Pp. 342. New York, Grune & Stratton. 1945. $4.00.

Hematology, for Students and Practitioners. By Willis M. Fowler. A.B., M.D., with a chapter by Elmer L. DeGowin, A.B., M.D. Pp. 499. New York & London, Paul B. Hoeber, Inc. Medical Book Department of Harper & Bros. 1945. $8.00.

Manual of Diagnosis and Management of Peripheral Nerve Injuries. By Robert A. Groff, M.D., and Sara Jane Houtz, B.S., with an introduction by I. S. Ravdin, M.D. Pp. 188 with 111 original illustrations. Philadelphia & London, J. B. Lippincott Company. 1945. $8.00.

The Care of the Aged (Geriatrics). By Malford W. Thewlis, M.D. 5th ed. Pp. 500 with 65 illustrations. St. Louis, C. V. Mosby Company. 1946. $8.00.

CASES OF INFLAMMATION OF THE SKIN due to sensitivity to nail-polish have been reported lately. Eruptions tend to occur about the face, eyelids, neck and arm.

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Tuberculosis Abstracts

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XIX **March, 1946** **No. 3**

THE pitfalls, dangers and abuses of bed-rest have been discussed in current medical journals by authorities in many fields. Probably this is a reaction to a form of treatment which has been prescribed with too little discrimination in certain conditions. This wholesome criticism should not obscure the fact that bed-rest continues to be as much a specific in tuberculosis therapy as does insulin in diabetes. Like insulin, bed-rest should be prescribed and used with precision and intelligence.

BED-REST IN TUBERCULOSIS

Current interest in the dangers from bed-rest challenges those who treat tuberculosis with bed-rest, which is the accepted and approved treatment. If bed-rest may exert a baneful influence on people ill of other disease, should it not on tuberculous patients? If the dangers do apply, are they commensurate with the risk from attempting to treat tuberculosis without bed-rest?

What are these dangers of bed-rest? In tuberculosis they are: (1) pulmonary infarction; (2) inadequate drainage of pulmonary lesions; (3) emotional maladjustment; and (4) improper correlation with collapse therapy. A brief discussion of these dangers of bed-rest seems indicated.

(1) Pulmonary infarctions: This has been regarded as a danger of paramount importance in people kept abed. What does the record show for this complication in the bed-fast tuberculous person? The Wm. H. Maybury Sanatorium with 845 beds has employed bed-rest and collapse therapy for almost twenty years. Approximately one-half of the patients at any time are not allowed to leave their beds for any reason. Such bed-fast patients may be terminal patients, the average new admission, and many other patients with reasonable prospect of recovery.

The first group furnishes nearly all of the postmortem material. During 18 years, among the 751 postmortem examinations there have been signs of pulmonary embolism in 11 cases, an incidence of 1.5 per cent. Nine of these came from terminal patients. The other two patients had a poor, but not necessarily hopeless, prognosis. Thus in only two instances could infarction appear to have contributed to the fatality. From the experience, pulmonary infarction does not appear to be a danger of great consequence to the tuberculous patient.

(2) Inadequate drainage of pulmonary lesions: Bed-rest may mean many things to many people. To some the only limitation on the activity of the patient is that he remain in bed. This is bed-rest in name only and is relatively inert therapeutically. To others it has an increasing therapeutic value as absolute immobility is approached. Unreasoning adherence to this concept fails to allow for pulmonary drainage, especially cavity drainage.

In many sanatoriums so-called "postural rest" is applied to patients with unilateral cavitation. The patient is encouraged to lie on his "cavity side" to protect the less involved lung from positive sputum. The behavior of iodized oil in the chest during cough suggests that the entire tracheobronchial tree, in the presence of cavity, may be bathed frequently in cavitary contents, and thus be contaminated with tubercle bacilli. It would seem then that "postural rest" encourages stagnation of sputum which should be drained.

(3) Emotional maladjustment: It is a rare person who can accept undaunted a diagnosis of tuberculosis. For him this is a catastrophe of world-shaking magnitude. He could well use the services of a psychiatrist, a sociologist and a philanthropist. Instead, we give him a hospital number, commit him to bed under an inflexible routine and henceforth concern ourselves only with the status of his thoracic contents. Many patients

adapt themselves, but in others tenseness, apprehension or dependency are common, as are complaints of muscular pains and exhaustion. Cough may be unnecessarily severe. In this way the patient fails wholly to take bed-rest although he remains in bed. That such patients tolerate bed-rest poorly in no way relieves us of our responsibility. Proper bed-rest is too valuable a tool to be used in a haphazard and reckless way. It is wholly worthy of the physician's best attention.

(4) Improper correlation with collapse therapy: Bed-rest and collapse therapy are integral and complementary parts of the sanatorium regimen and allow no competition. A well-balanced therapeutic program for the tuberculous patient employs all proved methods of treatment, combining them as judgment and experience indicate.

Bed-rest is the foundation therapy and upon its integrity depends the success of the entire treatment. When of high quality, great confidence may be placed in it, and collapse procedures may be added immediately, deferred or withheld, depending on the indications. With a well equipped collapse program, exacerbations appear to be related more often to improper rest than to any other factors. It is significant that physicians who relegate bed-rest to nursing supervision have little confidence in it and prefer to rely wholly on collapse procedures.

What, then, is good bed-rest? Krause had defined rest as relief from strain. In bed-rest, mental repose and muscular relaxation are vital features and any rest regimen without them cannot be considered a therapeutic procedure. It is a sensitive therapy which reflects the care and finesse of its administration. It is a medical problem to be handled only by physicians of proper temperament and training.

Much time must be spent with a patient in helping him to become adjusted. Psychological, social and economic problems must be discussed with him and simplified. He must be indoctrinated with a philosophy which permits him to accept his disease with equanimity and to submit completely and cheerfully to rigid discipline. Thus the seeds for future rehabilitation are planted at the very inception of treatment and many troublesome emotional maladjustments avoided.

Muscular relaxation comes unnaturally to many patients and may be taught only by daily, painstaking repetition. Once achieved, rest in bed becomes pleasant and comfortable. Great insistence should be placed on change of position frequently enough to insure adequate drainage of all parts of the chest. This will involve lying in prone, supine and both lateral positions. Stasis of contaminated secretions in normal areas of the lung must be avoided just as zealously as drainage of diseased areas is encouraged.

Good bed-rest, accordingly, is a precise method of treatment with clear-cut specifications and is based on three fundamental principles: mental repose, muscular relaxation and adequate drainage. Other details are less important and may vary with the type of nursing care available—this without materially affecting final results. The excuse that facilities for good bed-rest are lacking can be rarely substantiated.

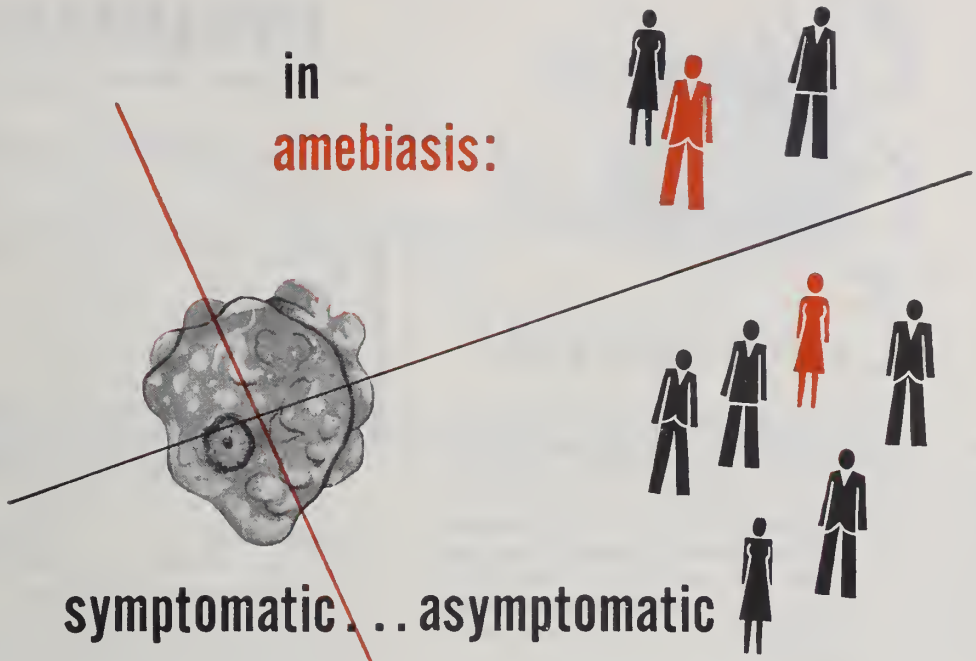
Bed-rest in Tuberculosis, William M. Peck, M.D., and Henry Stuart Willis, M.D., American Review of Tuberculosis, July, 1945.

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1. *Barr, D. P.: Modern Medical Therapy in General Practice, 2:1830, Baltimore, Williams & Wilkins Company, 1940.*
2. *Stitt, E. R.; Clough, P. W., and Clough, M. C.: Practical Bacteriology, Haematology and Animal Parasitology, ed. 9, Philadelphia, P. Blakiston's Son & Co., 1938, pp. 410-412.*

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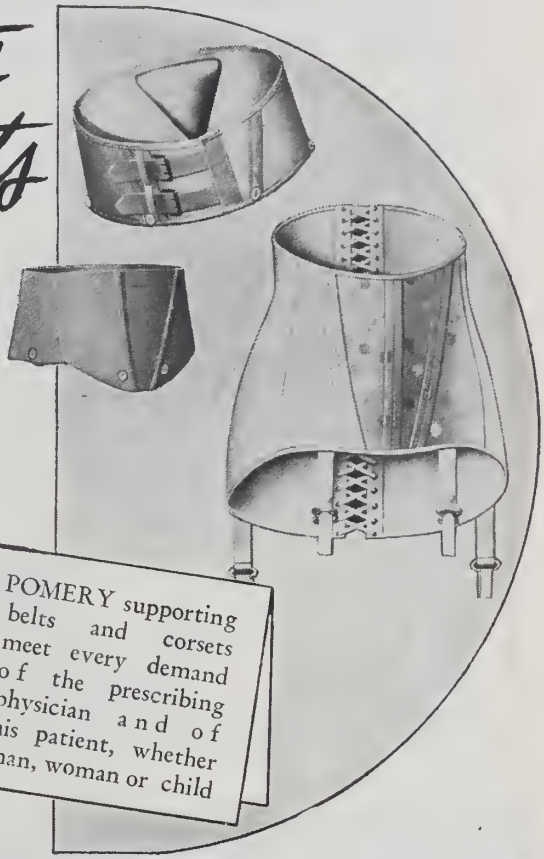
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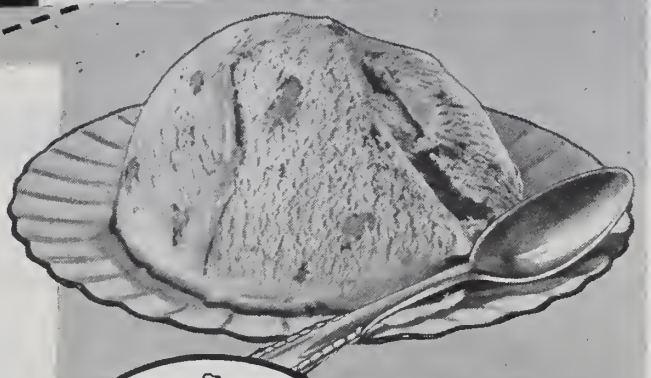
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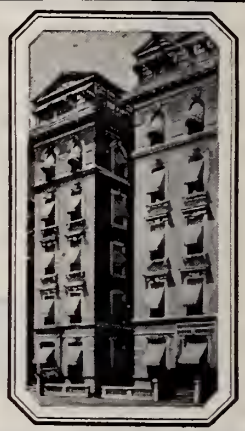
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ANNUAL MEETING, MAY 21, 22 and 23, 1946
CLARIDGE HOTEL, ATLANTIC CITY

THE JOURNAL

OF

THE MEDICAL SOCIETY OF NEW JERSEY

Entered as second-class matter, September 5, 1906, at the post office at Orange, New Jersey, under Act of March 3, 1879.

VOL. 43, No. 4 APRIL, 1946 Subscriptions, $3.00 per Year
Single Copies, 30 Cents

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Place of Publication, Printing and Mailing:
12 South Day St., Orange, N. J.

Editorial and Executive Offices of the Society:
315 West State St., Trenton 8, N. J.

Send all communications to the Trenton Office, telephone Trenton 5776

Acceptance for mailing at special rate of postage provided for in Sec. 1103, Act of Oct. 3, 1917, authorized July 29, 1918.

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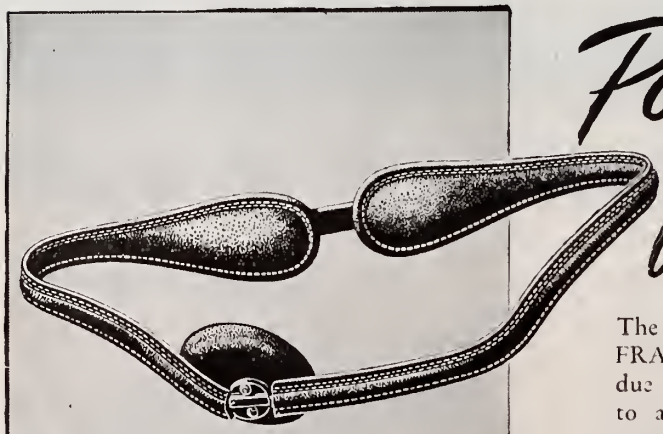
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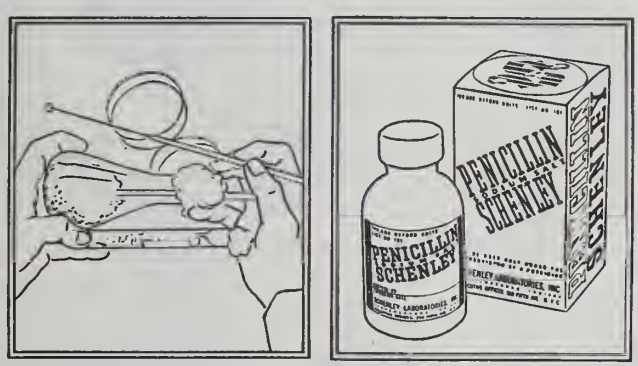
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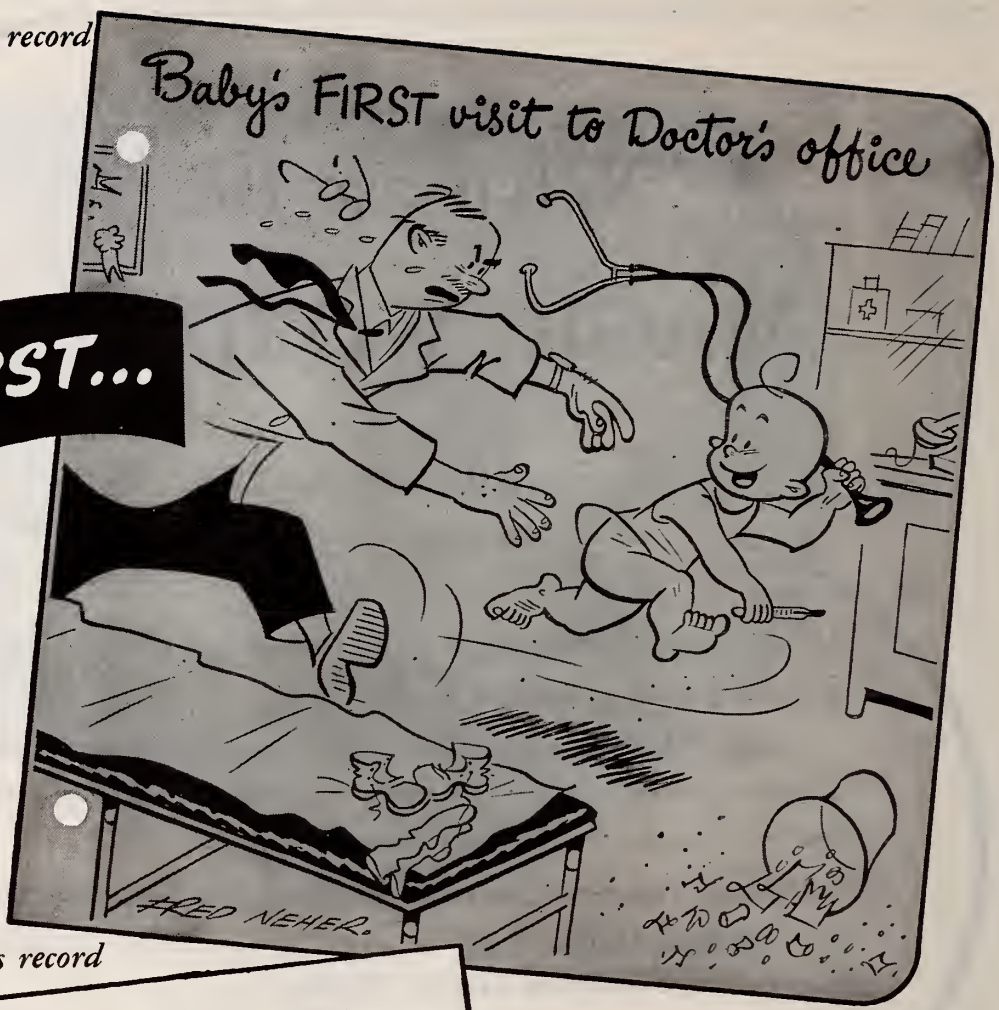
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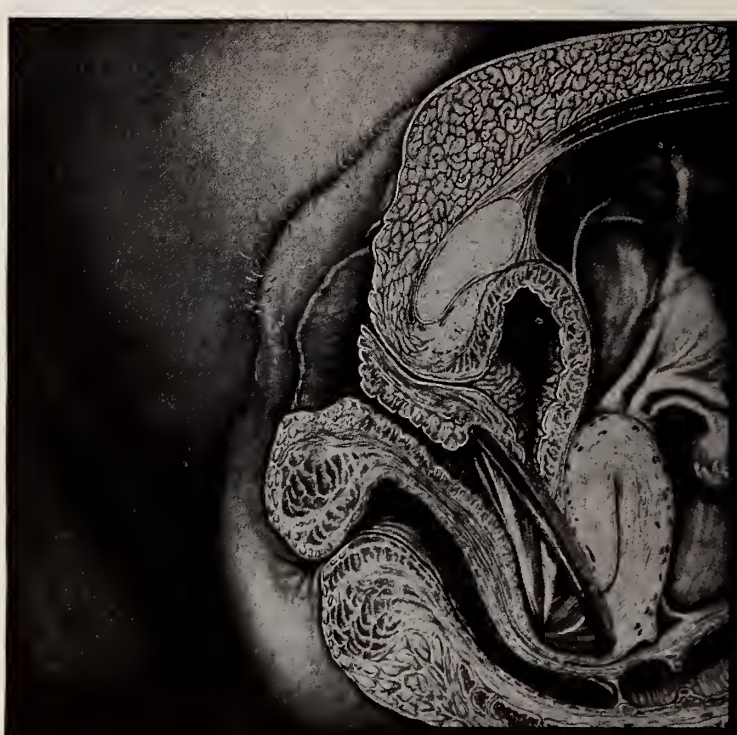
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1. Dickinson, R. L.: Techniques of Conception Control. Baltimore, Williams and Wilkins Co., 1942.
2. Eastman, N. J., and Scott, A. B.: Human Fertility 9:33 (June) 1944.
3. Warner, M. P.: J. A. M. A. 115:279 (July 27) 1940.

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1. Smull, K., Wegria, R., and Leland, J.: The Effect of Sodium Bicarbonate on the Serum Salicylate Level, J.A.M.A. *125*:1173 (Aug. 26) 1944.

2. Coburn, A. F.: Salicylate Therapy in Rheumatic Fever, Bulletin Johns Hopkins Hospital *73*:435-464, December, 1943

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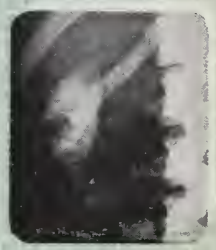
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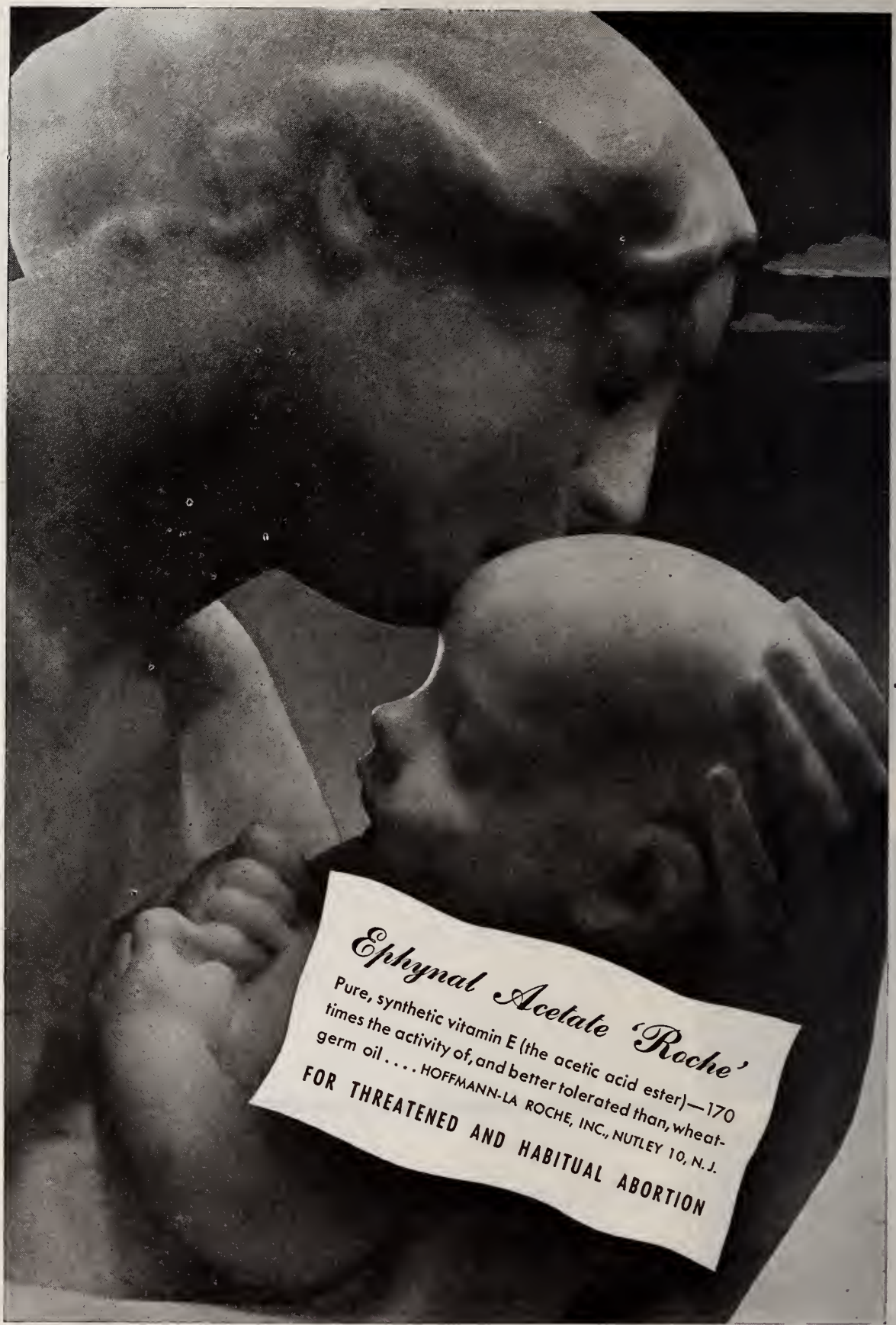
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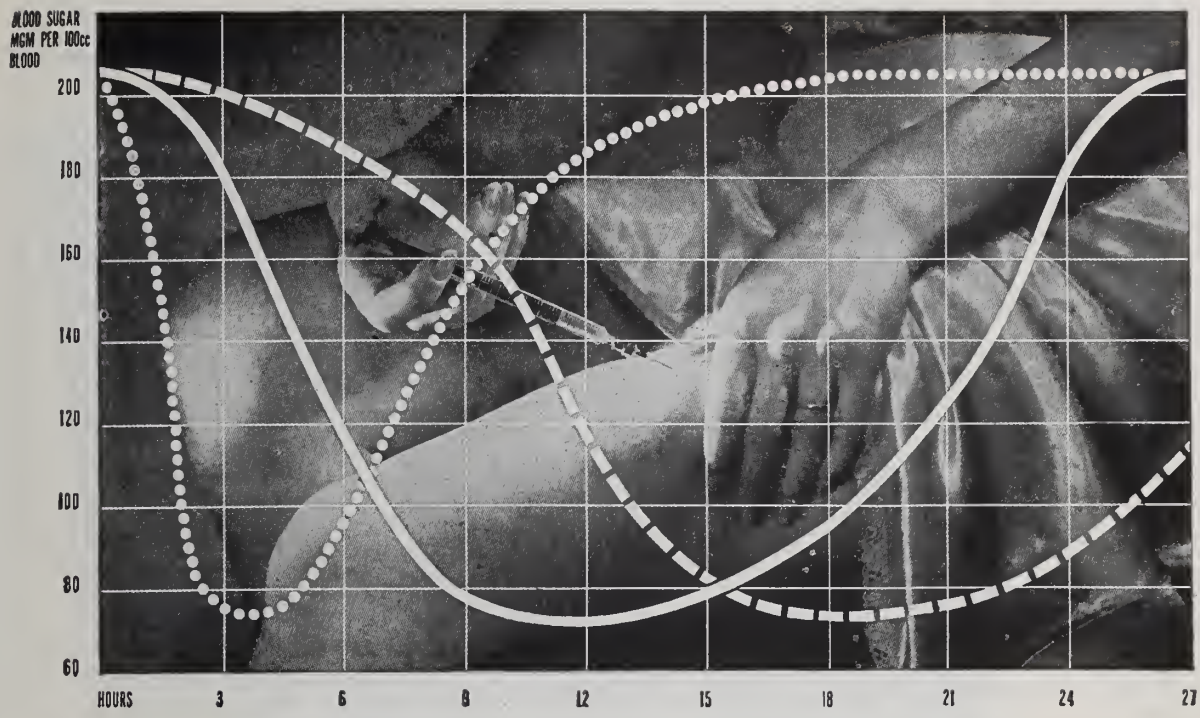
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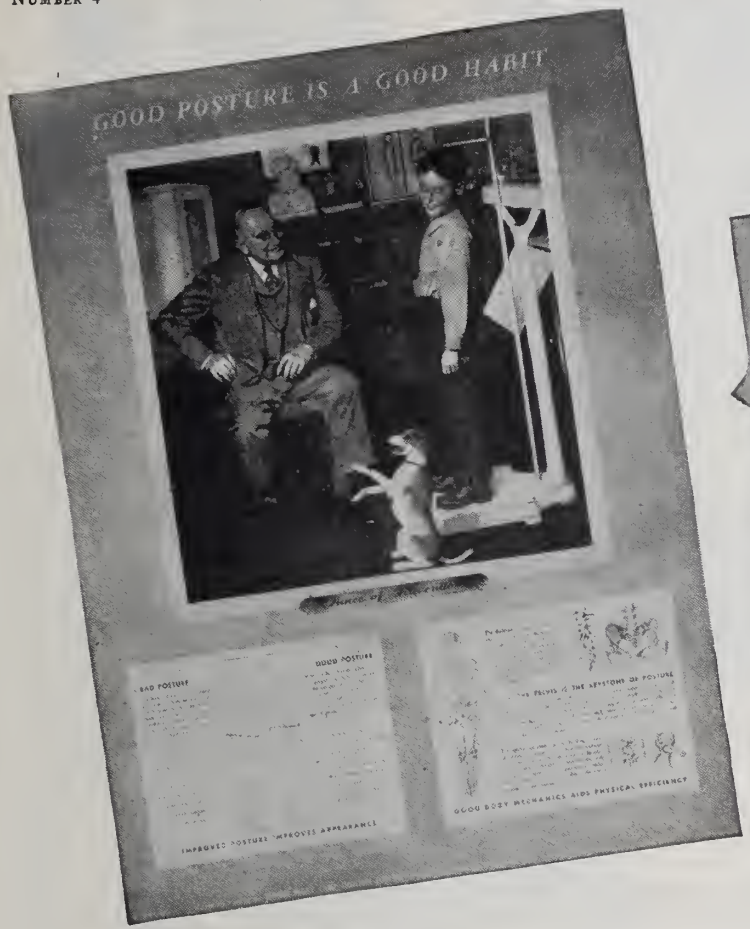
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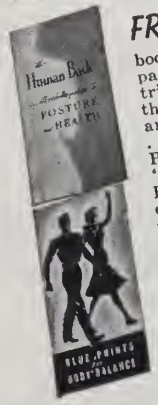
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Since no field is more subject to the dangers of "glamorizing" and lay "experting," the Institute in all its appeals stresses the necessity of "seeing your physician" as the first step in the improvement of poor body mechanics. Distribution of authentic literature through schools, colleges, medical and government bodies; and industrial, professional and civic public health groups is an important part of the program. Press and radio give serious coverage.

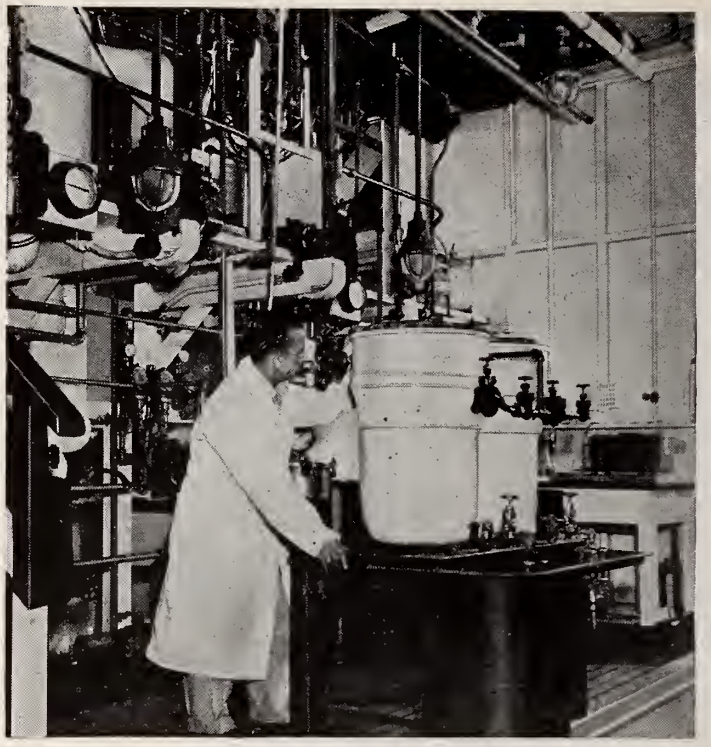
We hope to merit the continued cooperation of the medical profession during the first post-war observance of National Posture Week as peace presents its varied problems to those charged with maintaining the health of the nation.



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*Wright, H. E.: Tri-State Medical Journal, July 1939

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Published Monthly Since September, 1904
Whole Number of Issues, 500

Under the
Direction of the
Committee on Publication

Henry C. Barkhorn, M.D., Chairman

Henry A. Davidson, M.D., Editor

Place of Publication, Printing and Mailing—12 South Day Street, Orange, N. J.
Editorial and Executive Offices of the Society—315 West State Street, Trenton 8, N. J.; Tel. 5776
Send all communications to the Trenton Office.

Each member of the State Society is entitled to receive a copy of The Journal every month.

Vol. 43, No. 4 April, 1946 Subscriptions, $3.00 per Year
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EDITORIALS

OUR 500th ISSUE

This is our 500th issue. More than a hundred of our present readers were practicing in this state in 1904 when the first *Journal* of The Medical Society of New Jersey appeared. They will remember perhaps that in 1904, the President of the United States, elected on a "Square Deal" platform was a dynamic trust-buster named Roosevelt. Franklin Murphy was Governor of New Jersey. Newspaper headlines in September, 1904, reported "Japs Gaining as Russians Retreat from Outer Defenses." Leading editorial in the Newark *News* on September first began: "Child slavery in factories is this day abolished in New Jersey." Plaut's advertised shoes at from 87 cents to $2 a pair, while Goerke's offered men's all-wool suits at $5. Hahne's featured "fall weight horse blankets."

The new *Journal* opened apologetically: "When a conservative and dignified body like The Medical Society of New Jersey makes so wide a departure from long established usage as to publish its transactions monthly instead of annually, there should be good and satisfactory reasons." The reasons for a monthly *Journal* included "lack of interest amongst the younger men and their failure to take their share of the scientific and literary work of the Society." The first editorial sounded a call. "These are stirring times. Events rapidly take shape. The quack and the charlatan are ever vigilant. They wait not for the action of committees that report but once a year."

First scientific article in our *Journal* was written by Dr. Henry Mitchell of Asbury Park, then President of the So-

ciety. He spoke on *Preventive Medicine in New Jersey*, deplored the opposition to small pox vaccination and complained (in 1904!) that "manufacturers have stocked up our Boards of Health with useless and expensive apparatus." In those days, sanitation was a matter of disinfecting buildings, but Dr. Mitchell shrewdly observed: "It is the patient himself who is the principal source from which infection spread." His recommendation—a novel one at the time—was cleaner garments and more frequent baths. The next scientific article—it was by Dr. H. W. Elmer of Bridgeton—concerned the transmission of typhoid fever. Some communities used to resist the spread of railroads then for fear that "passengers who had typhoid would scatter along the track infectious material contaminating the soil and water." The state's mortality rate analyzed that year showed that Long Branch had the highest death rate in New Jersey; to which the Monmouth County Society retorted: "Long Branch is a summer resort with a large floating population amongst which are many invalids; the high death rate is not fairly chargeable to that town."

Leafing through the first volume we note that in the October 1904 issue, "salicylate of soda is recommended as a specific for thinning the bile and dissolving gall stones." In November appeared an article entitled: "The Physical Excellence of the Youth of Japan." In the same number is a paper on *Symptomatology of Appendicitis* by Dr. Thomas W. Harvey of Orange. It was one of the earliest papers ever written on the subject and Dr. Harvey's description of the clinical picture would be accurate today —and a lot more vivid than contemporary medical descriptions usually are. In those days the *Journal* published jokes. "My brother has been greatly benefitted by patent medicine." "What kind does he take?" "Oh he doesn't take any; he's a pharmacist." This is a joke.

Our state *Journal* took occasion to chide the *Journal of the A. M. A.* in November, 1904, for having printed advertisements for patent medicines without indicating the formulae. When the *J. A. M. A.* later did print the formulae, our state *Journal* commented: "While this might strike some as eleventh hour repentance, it is a gratifying sign of progress."

The state editor then, as now, had difficulty getting county reports on time. He wrote to the reporters: "We appeal to the county officers to report the Society's work. Gentlemen, brethren, colleagues, let not this appeal pass unheeded." Your present editor says amen.

The December, 1904, issue contained an article on bacillus aerogenes sinusitis written by a young otologist named Wells P. Eagleton. It was his first contribution to our local medical *Journal.* It was not his last.

The same issue carried a plea for the wider installation of indoor plumbing in dwelling houses and an article condemning the use of gauze as a surgical dressing. (It harmed tissue and served as a foreign body.) The *Journal* published an article which praised the Chattanooga Vibrator as an apparatus helpful in neurasthenia, neuralgia, goiter and hemorrhoids. In the first volume also is a note about a proposed trolley car sanatorium for "pauper consumptives." The idea was to tow a fleet of trolleys to the Hackensack Meadows and fix them there to serve as permanent habitations for tuberculosis victims. (Perfectly healthy veterans would eagerly rent space in them now if they were still there.)

In Elizabeth, according to an early communication published in our *Journal,* a medical club was being formed. "The club will establish a black-list and employ a bill collector, and bind its members not to attend lodge subscribers for less than the regular fees. However, we are broad

liberal minded doctors and are willing to give and take."

Public Relations in 1904 were still in their rough-and-tumble stage. An editorial on *Spitting in Trolley Cars* recounted an interview with Colonel Hine of the Public Service, and mentioned that "The Colonel who seems to be a past master in repartee, escaped after having given vent to his usual glittering generalities." The March, 1905, issue reports that among 18 cases of whooping cough, 17 patients were greatly benefitted by wearing an abdominal belt. In the following month, the editorial concluded that appendicitis was due to the eating of meat, and that "harmful excess of nitrogenous products sets up an inflammation in the appendix."

The Annual Meeting of 1904 was frequently mentioned in that first volume. One of the standing committees was a Special Committee on Mosquitoes and Malaria. Drs. H. Garrett Miller, Henry B. Diverty, Charles Teeter and L. T. Salmon, who are still with us, were members of that 1904 committee. "The Committee on Arrangements," read the memorandum, "respectfully announces that the Hotel Chelsea has been selected as the meeting place." Wonder why we don't say "respectfully" any more? The hotel, incidentally, was listed as "within two squares" of the trolley line. (The term "squares" for "blocks" persisted in Atlantic City until relatively recent times.) The hotel rooms were $3 a day then and the Annual Meeting included a "musicale and a smoker"—but no cocktail party. All meetings in those days began with an invocation by a clergyman.

In its 42 years, the *Journal* has had only four Publication Committee Chairmen. They were: Dr. William J. Chandler of South Orange, from 1904 to 1915; Dr. August A. Strasser of Arlington, from 1915 to 1917; Dr. Charles D. Bennett of Newark, 1918 to 1930; and Dr. Henry C. Barkhorn of Newark since 1930. In the same period there have been only five editors (excluding Dr. Shipley's three months' incumbency of the chair in 1933). They were: Dr. R. C. Newton of Montclair, from 1904 to 1906; Dr. David C. English of New Brunswick, from 1906 to 1924; Dr. Henry O. Reik of Atlantic City, from 1924 to 1933; Dr. Frank Overton of Patchogue, L. I., from 1934 to 1941, and Dr. Henry A. Davidson of Newark since 1941.

At the time of its first issue, the *Journal* went to a thousand doctors, the complete membership of The Medical Society of New Jersey in those days. Of those thousand, 114 are still reading the *Journal* today. Their names are recorded on page 145 of this issue.

At the end of its first year of publication, an editorial referred to the *Journal* as a lusty infant and closed with the remarks: "We hope that the father of the child, The Medical Society, will conclude that the young one is worth raising."

The lusty infant has attained an honorable maturity now: 42 years and 500 issues old. Its pages carry accounts of the use of sulfanilamid and the effects of atomic radiation when once they wrote of tincture of musk and the value of long bicycle rides. We have drugs and skills and problems, too, of which they never dreamed back in 1904. But in the field of clinical acumen, ethical meticulousness, professional dignity, and cultural depth, the doctors at the turn of the century still merit a respectful salute. One can't help thinking that they did more with what they had then we ever do today.

THE PRACTITIONER AND THE CHRONIC ALCOHOLIC

In theory, physicians accept the thesis that alcoholism is a disease. In practice, few M.D.'s want to "treat" chronic alcoholics. These patients are difficult to handle, make scenes in the office, summon the doctor at odd hours, and involve him in the murky backstage of the family drama. And even with a willingness to work with alcoholics, the practitioner is stymied by the lack of inexpensive institutional facilities. In many, indeed in most, communities there is not a single general hospital which will knowingly admit an alcoholic. In a few larger cities, alcoholics—acute or chronic—are admitted to psychopathic wards where the therapeutic atmosphere is poor and the indiscriminate mixing of psychotics, epileptics, defectives, psychopaths and alcoholics makes it difficult to handle properly any one of these groups. If we believe alcoholism is a disease, we must take the lead in providing adequate institutional facilities. Otherwise and by default, alcoholics will be diverted to jails, missions, and cultists.

Perhaps the idea of alcoholism as a disease needs some rethinking. At least two objections may be raised to this concept. One is that the patient, taught to pity himself as a "sick man", can yield to his compulsion without guilt feelings, and justify it on the grounds that after all he is not responsible for his being sick. The second objection is that while alcoholism is what the doctor, by broad gage definition, does call a "disease", it is not what the layman means by the word "disease". A layman thinks of disease as something coming from without, producing an effect upon a helpless body which the doctor can alleviate by medication or by procedure. We doctors think of disease as any deviation from average. In the layman's sense of the word, alcoholism is not a "disease". It is reported that that unique organization *Alcoholics Anonymous* has achieved "cures" (measured by one year of sobriety) in 84 per cent of its subjects. Let it be noted that these effects were not produced by doctors, but by laymen. A disease does not act that way. For instance, it is M.D.'s, not laymen, who have the highest proportion of success in treating psychoneurotics, a fact which tends to support the classification of psychoneurosis as a "disease". Continuous underscoring of the "disease" feature of alcoholism tends to absolve the patient from participation in his own treatment.

There seems little likelihood, however, that the medical profession will surrender the concept of alcoholism as a disesae. If we insist on this label, we must be prepared to meet the challenge implicit in it: if it is a disease, then we doctors must do something about it. The recent Rutgers survey indicates that most physicians who treat chronic alcoholics depend entirely on sedation and vitamins—a manifestly inadequate regime for long-term treatment. Amphetamin is used by only 14 per cent of the physicians. An even smaller proportion were able to administer anything approaching genuine psychotherapy. Perhaps the first requisite is a willingness on the part of the M.D. to undertake the treatment. Next is a willingness to learn modern methods of therapy, to understand what is meant by reconditioning, to develop some skill in psychotherapy, to know how to use the newer drugs. Finally, there is pressing, almost desperate need for suitable institutional facilities, where alcoholics may be housed, studied and treated. If physicians want to retain jurisdiction of the treatment of these patients, it is fitting for them to take leadership in activating the community to provide the necessary institutional facilities.

ORIGINAL ARTICLES

SUBLINGUAL ADMINISTRATION OF PENICILLIN

James T. Hanan, M.D., F.A.C.S., Montclair, N. J.

Few practitioners are aware of the availability of the sublingual space for quick absorption into the blood stream of penicillin-sodium in solution, by way of the ranine veins under the tongue. For some months I have been using this area to promote a rapid blood level of penicillin when oral medication was indicated. Systemic absorption from the sublingual space nearly equals that from a subcutaneous injection. Indeed, some authorities believe that it is even more rapid.

Clinically judged, results by this route have been prompt, uncomplicated and curative; only one patient so far, after a ten-day period of administration, has complained of tender mouth lasting about a day. There has been no bowel disturbance such as frequently occurs when tablets of penicillin-calcium are administered by mouth. And, in correspondingly effective amounts, penicillin-sodium costs the patient only a third as much as penicillin-calcium.

Ten thousand units of penicillin-sodium in the sublingual space hourly are more efficient than 25,000 units of penicillin-calcium given in tablet form by mouth every two hours. This is so because of more rapid and direct absorption from the sublingual space into the blood stream.

It was impossible during this time to secure reliable laboratory estimates of blood levels. Two commercial laboratories were asked as well as the Pathologic Department of a large hospital in my vicinity. Shortage of assistants, pressure of routine work and a rather complicated method of determination, without much previous experience, have been the reasons advanced by them for not being able to perform these tests.

ADMINISTRATION

The blonde, or light yellow penicillin-sodium is more soluble and less bitter than the brunette or darker varieties and is preferred for sublingual use although either may be given.

Basic formula is 100,000 units of penicillin-sodium, 5 cubic centimeters of isotonic solution of sodium chlorid and one drop of spirits of peppermint which does not contain enough alcohol to precipitate the penicillin and does give a cooling, pleasant sensation to the somewhat bitter drug.

A usual prescription for 40 doses of 10,000 units each is:

℞ Penicillin sodium ..... 400,000 Units
(light yellow)
Liq. Sod. Chlorid. Isoton ..... 20 c.c.
Spt. Menth. Pip. ..... 4 drops—m

Sig. Place 10 drops under the tongue as directed, every one to two hours. (Keep refrigerated.)

This gives 40 doses of 10,000 units each; ten drops equalling half a cubic centimeter. This dosage may be given hourly or every two hours in acute conditions. The interval may be extended to three hours when symptoms are less pressing.

To the patient the following oral directions are given:

1. Roll the tip of the tongue toward the roof of the mouth exposing the sublingual space behind the lower teeth.
2. Put the prescribed number of drops in this cavity.
3. Return the tongue slowly to its normal position and refrain from swallowing for one minute.

As sublingual medication has nothing to do with stomach secretions dosage may be carried out anytime without regard to food intake.

SUMMARY

Penicillin may be given effectively and inexpensively by the sublingual route. Basic formula is 100,000 units of penicillin-sodium with 5 c.c. of isotonic sodium chlorid and a drop of spirits of peppermint. Ten drops are placed under the tongue every hour or two.

COUGH IN TUBERCULOSIS *

CHARLES HYMAN, M.D., Atlantic City, N. J.

Most common but perhaps most neglected symptom in pulmonary tuberculosis is cough. As soon as the diagnosis is established the disability produced by this symptom is forgotten. It is accepted as a part of the disease just as is fever, weight loss and cavity formation. Yet no one of these, or all three of them put together disturb the patients as much as the cough. It disturbs their sleep, their appetite and their mental state. It may be a factor in spreading the disease to other areas of the lungs.

Complete relief of cough in all cases is impossible. Many are beyond alleviation. But if it can be relieved in even a small proportion of cases we will be contributing to the comfort of that group at least. Cough deserves relief because it interferes with the sleep of the patient and the neighbors in the ward. Bacilli may be discharged into the atmosphere with its attendant dangers to others. Cough may spread bacilli to healthy areas of lung thus increasing the extent of the disease in the patient himself. Paroxysmal cough sets up esophageal reflexes that cause emesis and all its evil effects. Finally, uncontrolled cough produces more cough.

MECHANISM

Cough is a reflex induced by irritation of the respiratory mucosa. The reflex may be set up anywhere from the alae nasi down to the smallest bronchiole. A similar reflex can be produced at the pleural surfaces. Some authorities believe that similar reflexes can be initiated in the gastrointestinal tract and the pelvic viscera. Unless there is diaphragmatic pressure from these areas, it is doubtful if this mechanism is effective. When such pressure does occur, the irritation of the diaphragmatic pleura is probably the source of the reflex. Certainly in most cases, we need not be concerned with any focus other than that in the respiratory tract.

There are two stages in this mechanism; first a deep inspiration and then a violent expiration. The latter consists first of a short compressive phase in which the glottis is closed and the expiratory muscles contract, bringing the intrapulmonary pressures to a high level. This is followed by the expulsive phase when the glottis opens slightly while expiration goes on so that a violent draft of air is produced tending to expel any material present in the bronchi. The diaphragm is a factor in the inspiratory phase only where it plays simply a passive part. During the expiratory phase the major rôle is played by the abdominal muscles which forcibly contract and exert pressure on the viscera, which in turn push the diaphragm up, thus increasing the intrathoracic and intrapulmonary pressures.

CONTROL

A consideration of the pathologic anatomy and physiology will indicate the approach to treatment. If one thinks of cough as either useful or useless a clue to treatment is found. *Useful cough* has for its purpose the expulsion of infected or extraneous matter from the bronchopulmonary tree. In those cases, efforts must be made to get rid of these secretions. Obviously the control of the disease itself by rest and the selective measures of collapse is the outstanding treatment. Liquifying secretions with full doses of ammonium chloride and a regime for increasing the fluid intake are valuable measures. Mechanical measures such as bronchoscopy, postural drainage and transpleural cavity drainage are useful in selected cases. Bronchoscopy in the hands of a trained operator is a safe and beneficial therapeutic and diagnostic measure in many cases of pulmonary tuberculosis. Postural drainage can not be well tolerated by patients with far advanced disease but may be useful in unilateral disease. Monaldi cavity drainage is not yet well enough developed for routine use.

Useless cough may be due to irritation from infection in the upper respiratory tract, post nasal drip, sinus infection and nasal polyps.

* Read before the Staff of the Atlantic County Hospital for Tuberculous Diseases, Northfield, N. J., April, 1945.

Certain coughs are due to habit and nervousness. Smoking may be a factor, as well as environmental influences such as improper ventilation, sudden drops in room temperature, and humidity. In such cases, excellent results are obtained from adequate drainage of sinuses, clearing of tonsil crypts and adenoids. Education of the patient to voluntary suppression and quiet breathing will give many a large measure of relief. A routine of keeping sleeping quarters at an even temperature, free of drafts and at proper humidity will go far in giving these patients quieter nights.

Use of opiates in treatment of intractable cough requires special consideration. Some authorities assert that since you are dealing with a chronic condition, this type of medication should be withheld because of the danger of habit formation. It is my feeling that if this point of view is allowed to dominate one's judgment, it will simply add to the suffering of one already doomed to death with the disease. A doctor who understands tuberculosis and the course it takes in many of the far advanced pulmonary and laryngeal cases should be able to make a reasonably accurate prognosis. Certainly in tuberculosis as in carcinoma it is not too difficult to determine the hopeless cases. When pain is the striking feature in inoperable and hopeless carcinoma we have learned to approve of opiates to the point of narcosis if necessary. In a like manner, we can judge the hopeless tuberculous patient and if the cough is the equivalent of the pain of the carcinoma case we should be bold enough to use sufficient narcosis to make his remaining days as comfortable as possible. What if he does linger for months and requires more and more morphine? Cancer cases are carried for years on narcotics and no doctor need feel guilty of having induced a "habit". If you do not spare the morphine to relieve pain in inoperable carcinoma, why spare it in relieving the cough in tuberculosis?

2807 Pacific Avenue

STREPTOMYCIN SHORTENS CONVALESCENCE PERIOD IN TULAREMIA

A new bacteria-destroying substance called streptomycin, derived from a soil microbe, similar to penicillin, has relieved the symptoms in tularemia within 12 hours of administration, according to Lee Foshay and A. B. Pasternack.

To date there has been no specific treatment for this disease, sometimes called "rabbit fever". The doctors' report, appearing in the February 16 issue of *The Journal of the American Medical Association*, is based on the treatment of seven patients infected by handling wild rabbits.

Drs. Foshay and Pasternack, who are from the Departments of Bacteriology and of Medicine, University of Cincinnati College of Medicine, and the Cincinnati General Hospital, say that the disease usually causes 31 days of fever, keeps the patient in bed 31 days, and has a duration period of four months.

With the administration of streptomycin, the doctors noted, patients experienced relief from the distressing general symptoms of headache, mental dullness, sense of prostration, joint pains, muscle pains, chills or chilly sensations and nausea before the end of the first day of treatment. The authors feel that the action of this drug will greatly reduce the period of convalescence.

The dosage, 30,000 units injected into the muscles every three hours, was administered for five days. With further experience the doctors recommend a larger daily dosage to be injected beneath the skin rather than into the muscles.

Tularemia is sometimes called "rabbit fever" for almost 90 per cent of human infections result from contact with the infected tissues, body fluids or pelts of rabbits. The disease is characterized by swellings of the skin with the formation of abscesses, swelling of the lymph glands and small spots of infection in the internal organs.

Streptomycin, which has successfully attacked diseases not affected by either penicillin or the sulfonamides, was discovered by Selman A. Waksman, of the New Jersey Agricultural Experiment Station, Rutgers University, in 1943, but is not yet generally available.

SHOCK THERAPY AT THE ESSEX COUNTY HOSPITAL

HENRY G. SMITH, M.D., Cedar Grove, N. J.

Nothing in institutional history has so favorably affected the mental hospital parole rate as the utilization of shock and convulsive therapy. True, these methods are empirical: but so are many other technics successfully employed in medicine and surgery.

PHYSIOLOGY

What is the physiologic basis for shock therapy? The brain, it has long been known, utilizes oxygen. Carbohydrates are the most important foodstuff used in cerebral metabolism. Now the oxygen intake after insulin convulsions is appreciably less than normal consumption. As might be expected, insulin injections effect a diminution in the sugar content of brain tissue. This in turn diminishes oxygen consumption, provoking a cellular anoxemia which is responsible for the confusion, excitement and convulsions seen in hyperinsulinism. With insulin-induced hypoglycemia, the brain's respiratory rate is diminished; with the addition of lactose or glucose to the blood stream, it is accelerated. Within certain limits, the alternating effects of oxygen and glucose deprivation are reversible. Beyond these limits the cellular anoxemic effects may become irreversible and result in permanent damage to brain cells. Histopathologic study indicates that there is a marked asphyxia of brain tissue. When that occurs, the reversibility of the reaction depends largely on the depth and duration of the asphyxia to which the brain is exposed. The loss of brain cells may be relatively harmless, as has been demonstrated by lobectomy; but with general brain cell asphyxia not many may be lost without causing mental impairment.

Cardiazol (or metrazol) does not produce lowering of the blood sugar, but diminishes brain metabolism by binding the oxygen that would normally be available for the combustion of the blood sugar. After the convulsion the oxidization rate is not materially depressed but the carbon dioxid combining power is diminished with increase in the blood oxygen content lasting about two hours.

The acuteness of the metrazol and electric convulsive effect in depressing brain metabolism accounts for the clinical observation that these patients have an amnesia for events immediately prior to and during the convulsive seizure. Following a convulsion, basal metabolism rises and then gradually regresses within several hours to normal. Brain metabolism recovers more rapidly following metrazol or electric convulsive shock than it does following insulin, but corresponding hemorrhagic lesions have been reported in the brain. Some psychiatrists have combined insulin and metrazol by producing a metrazol convulsion after 2 hours of insulin. I used this combined therapy for some weeks on nine cases, but results were the same as when I used either drug alone.

UNTOWARD EFFECTS

During our second year of insulin therapy, we had one death from pneumonia as the result of vomiting and aspiration of glucose sol. This was my only fatality in 6 years during which 520 patients were treated with insulin shock. In another service at our hospital, however, there were three deaths as the result of pneumonia and irreversible insulin shock. Autopsy showed the subarachnoid edema and punctate hemorrhages throughout the brain.

There were no deaths following metrazol therapy though we had innumerable subluxations of the jaw. The patients were not aware of it at the time, and no permanent damage has been observed. In two patients, there was dislocation of the humerus. Routine x-rays of the spine were, with one exception, negative; this was a tribute to the extreme care used in manual restraint during the convulsive seizure. The one exception occurred when a patient suffered a compressed-lipping fracture of the first lumbar vertebrae while being held by a new student nurse. One received a depressed fracture of the acetabulum due to muscular contraction forcing the head of the femur partly into the pelvis. Many workers reported high rates of spinal fractures, and we feel fortunate

in our choice of manual restraint with adequate nurse assistance for the small number of injuries at our hospital.

ELECTRIC CONVULSIVE THERAPY

We began the use of electric-convulsive therapy in February, 1941, on a group of patients who had previously had insulin or metrazol or both, without adequate improvement. Electric therapy acts as does metrazol by producing a complete and immediate convulsive seizure of from five to forty seconds duration and a postconvulsive somnolence of five to thirty minutes. On awakening, the patients show a complete amnesia for the period beginning a few minutes before the convulsion, often asking if they may be the next to be treated. Occasionally there is an involuntary sphincter relaxation. With increased convulsions there occurs a spotty type of amnesia when the patient cannot recall certain events or names. A few become temporarily disoriented during prolonged treatment. This amnesia lasts from a few days to several weeks. Our longest amnesia lasted four months. The patient's conduct may become normal after a few convulsions with absence of delusions or hallucinations. It is not an uncommon event for patients to state that they know they are well except for forgetfulness of things they ordinarily should recall, such as age, home address or names of members of their family. Some will ask how they can get their memory back now that they have recovered sufficiently to go home.

During a course of treatment the general morale of the ward is improved, disturbers becoming coöperative. New patients soon ask if they may have the therapy, and there is a spirit of comradeship never previously observed.

With all three modes of therapy there have been some relapses during parole, with return and additional therapy of the same or different type. While figures are not yet available on the metrazol and electric convulsive group, I have a definite impression that the re-institutionalization rate will be much smaller, at least among manics and involutional depressions.

INSULIN THERAPY

In a recent survey over a five-year period of the first 120 male, and 100 female schizophrenia insulin therapy patients who were allowed on parole, we find that 31 per cent have either recovered or attained satisfactory social and economic stability; that 55 per cent of the males and 63 per cent of the females returned to the hospital, while 6 males, and 3 females died from causes not connected with the therapy; 10 males and 2 females continue on parole.

These figures correspond closely with those of Ross in a survey of insulin therapy in all New York State Hospitals. Bond and Rivers have reported: "The results of insulin therapy with an immediate recovery rate of 55 per cent show a tendency to level off at about 33 per cent in the second, third and fourth years, and with a long distance recovery rate twice that of the controls the therapy seems justified."

It is my opinion and also the opinion of others on the hospital staff that many who have made normal social and economic adjustments would now be chronic hospital inmates if they had not had shock therapy.

REMISSIONS

The beneficial effects are often observed within two weeks, some after two or three treatments. Occasionally, in the insulin group, we would have a remission some weeks following cessation of treatment, while in a few cases we have had hypoglycemic reactions occurring as long as 3½ months after completion of treatment. This delayed remission we have not observed in the metrazol or electric group, but quite a few who show marked improvement during therapy, rapidly relapse on its termination. In the hope of salvaging these we have carried the treatment on, and on by the prolongation of their series or by repeated series with rest periods of varying duration or until relapse sets in. One patient, a destructive, homicidal, paranoid schizophrenic, had 181 insulin hypoglycemias with convulsions has shown some apparently permanent improvement, and after six years became a well behaved hospital resident. Another had 112 metrazol convulsions repeated in series of 15 to

TABLE 1

Proportion of Insulin-Treated Patients Who Were Paroled

Insulin Treated	Percentages Male	Female
Schizophrenia, paranoid	23	32
Schizophrenia, catatonic	40	44
Schizophrenia, hebephrenic	20	34
Manic, depressive, depressed	50	35
Manic, depressive, manic	—	76
Psychoneurotics	—	75
Average, all schizophrenic	29	49
Average, all manic-depressives	50	55
Average, all treated patients	39	56

Totals: 116 males, 247 females.

TABLE 2

Proportion of Female Metrazol Patients Who Were Paroled

Metrazol-Treated	Percentage Paroled
Schizophrenia, paranoid	50
Schizophrenia, catatonic	57
Schizophrenia, hebephrenic	50
Schizophrenia, unclassified	39
Manic-depressive, manic	86
Manic-depressive, depressed	47
Involution melancholia	66
Average, all schizophrenias	49
Average, all manic-depressives	67

Total: 191 female patients.

30 with incomplete remission but shows considerable improvement.

One involutional melancholia has had 121 electric convulsive seizures in the past two years with short intervals of comparative normalness, and then relapse. Others had complete remissions following three to eight treatments, and went home.

Minimal dosage of electric shock to produce a convulsion in depressed manics, and a subconvulsive shock has been sufficient in most psychoneurotics to restore a return to the previous normal state.

PROCEDURE

Electric convulsive therapy is easier to apply than the other modes. Complete absence of or minimal fear on the part of the patient as result of its being painless is helpful, even in the sub-convulsive shocks of 40 volts and 200 milliamperes, consciousness is momentarily lost and the patient has no sensation or memory of the shock. It also requires much less time on the part of the physician, leaving him possibly tired, but allowing more time for routine duties. Twenty-five to thirty treatments are given in an hour with the same trained personnel in the treatment section.

Many types of pathologic reflexes are observed and demonstrated during the coma or convulsion but none have remained after awakening, and so far no demonstrable neurological damage has been done.

INSULIN RESULTS

The proportion of paroles in the schizophrenics treated with insulin is shown in table 1.

Our parole rate is 55.78 per cent for female insulin-treated patients, and 38.93 per cent for males. This included female patients with hospital residence up to 19 years; 33 per cent had residence for over two years. Of the group under 6 months residence, there were 54 per cent allowed on parole. This coincides with the previously cited figures of Ross, Bond and Rivers.

METRAZOL RESULTS

The percentage of paroles in metrazol convulsive therapy for the years 1939-40, on 191 female patients, of whom 60 were dementia precox is indicated in table 2.

These figures give us a parole rate of 60.7 per cent for all female metrazol treated cases.

On the male service metrazol was used in conjunction with insulin on 73 cases, and alone on 9 cases.

RESULTS AFTER ELECTRIC SHOCK

The rate of parole in electric shock therapy for the two years 1941-42 on 162 female, and 118 male patients treated is given in table 3.

This gives us a parole rate of 65.27 per cent for all female electric convulsive cases, and 70.44 per cent on male patients. Seventy of these females were retreated cases.

These statistics show that with the three modes of treatment the dementia precox group had a parole rate of 46.7 per cent; the manic group 60.68 per cent; the psychoneurotics 87.5 per cent; the involutional melancholias 60.23 per cent.

TABLE 3

PROPORTION OF PATIENTS TREATED WITH ELECTRIC SHOCK THERAPY, WHO WERE SUBSEQUENTLY PAROLED

Electric Treated	Percentage Paroled Male	Female
Schizophrenia, paranoid	67	24
Schizophrenia, catatonic	50	41
Schizophrenia, unclassified	45	62
Manic-depressive, depressed	—	48
Manic-depressive, manic	86	46
Involution melancholia	—	54
Psychoneurosis	—	50
Average, all schizophrenics	54	42
Average, all manic-depressives	86	47

Total: 118 males, 162 females.

CONCLUSIONS

While results are more striking with metrazol and electric shock, ultimate results in schizophrenia are not as promising as with insulin; while in the affective groups (manic depressives and involutionals) the convulsive therapies at this date appear to be the method of choice in returning our patients to their homes.

In our efforts to decrease our mental hospital population, and the tax burden, and also to appease the families of our patients, many of whom, though economic assets to the community are also potential mothers and fathers, will the descendants of these released patients continue to fill our institutions? Of the one hundred female insulin therapy cases surveyed four returned to the hospital following childbirth, two were delivered after return, and another, recently returned, is four months pregnant. I cannot forget the adage "Once a precox always a precox." When recovered from a psychotic episode, do we return them to their homes to reproduce pathologic personalities, and psychopaths? What effect will this policy have on the mental hospital population during the next generation?

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SYPHILIS OF THE SPINAL CORD

The following clinical syndromes are due to syphilitic involvement of the cord:

1. Large vascular accidents involving the spinal arteries are an unusual condition. The best known example is thrombosis of the anterior spinal artery. The signs are a segmental loss of pain, temperature and manifestations of injury to the anterior horn cells, with varying amounts of damage to the ascending spinothalamic and descending pyramidal tracts. The acute paraplegias of syphilis are due to such vascular occlusions, and they may be followed by a partial return of function.

2. A diffuse meningomyelitis, often associated with small vascular occlusions, is also seen early in the disease. This form is a more common variety. Pain, due to root irritation, is a frequent feature. The upper thoracic cord is most often affected, and girdle pains are characteristic.

3. Erb's spastic paraplegia is a late form of syphilitic myelitis. The pyramidal tracts are most severely damaged, with only mild injury to other parts of the cord. Besides the spastic paraplegia, there are frequently bladder disturbances.

4. Progressive muscular atrophy is also a late complication. Here the anterior horn cells are the principal site of injury. The lower cervical cord is the most frequent location for this variety of spinal cord syphilis. Muscular atrophy and fasciculations are the usual clinical findings. Amyotrophic lateral sclerosis of syphilitic origin is a closely associated condition in which there is injury to the pyramidal tracts as well as to the anterior horn cells.

5. Gummas may occur after the first year of infection. The signs are those of cord neoplasm. Any portion of the cord or cauda equina may be the site of the granuloma. The results of therapy are usually good. However, there is one special form of massive, chronic gummatous process which is limited to the cervical region, known as hypertrophic cervical pachymeningitis. Symptoms and signs may be those of a mass, but they may simulate those of syringomyelia or amyotrophic lateral sclerosis. It is very resistant to treatment.

6. Tabes dorsalis is a process in which the sensory roots alone are damaged, resulting in ataxia, loss of reflexes, bladder disturbances, characteristic gait, and various forms of pain. It is usually a late complication of syphilis. One or several cranial nerves may be injured concurrently. While the site of the lesion is clear, its mode of production is not. It is not unusual to find the blood and spinal fluid serologic tests for syphilis negative.—(Author's Abstract.) Arthur B. King, M.D., Am. J. Syph., Gonor. & Ven. Dis., *26*:336-377.

THE WART AND ITS TREATMENT

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A wart is an epithelial new growth of the skin formed by hypertrophy of the papillae. Major clinical varieties are: the common wart *(verruca vulgaris)*, the plantar wart *(verruca plantaris)*, the flat juvenile wart *(verruca plana juvenilis)*, the venereal wart *(verruca acuminata)*; the *verruca digitata*, with numerous finger-like processes, and *verruca filiformis*, with long thread-like pedunculated cutaneous tabs. Seborrheic and senile warts are keratoses and do not belong in the papilloma group.

Although warts may persist for 30 years, they usually disappear in about three years without treatment after immunity has been established. In many cases, warts return after 10 to 12 years, and then they take much longer to disappear without treatment.

Cause: The most acceptable etiologic theory seems to be that most warts are caused by a filterable virus.[24, 9, 30, 26, 18, 2] Even some of the more mature types of skin tabs and papillomas, which have been present for years, may have had a virus origin, though the infection has long since died out.

The infectiousness of *verruca vulgaris* can be demonstrated by piercing a wart with a sterile needle and then scratching normal skin with it. In a few weeks a row of new warts can be seen along the scratch mark.

Papillomas in cottontail rabbits are produced by a filterable virus.[25, 18, 2] Warts also occur in dogs and cattle, and here a virus is the etiologic agent. They cannot spread from one species to another, however.

VERRUCA VULGARIS

The common wart is seen more often in children than in adults, and may appear singly or in crops. The usual site is the skin of the hands and fingers, but they can occur at any place on the skin or mucous membrane, and even underneath the nails. The virus is most likely to gain entrance at sites of scratches, trauma, and areas of pressure.

According to clinical age, warts may be pinhead size, half conical in shape, reddish and scarcely perceptible above the skin. In later stages they become elevated, hard, dry and greyish with furrowed, uneven surfaces. In still later stages we see deep ridges on the surface with papillomatous processes covered with a horny material. When this horny substance is removed grossly, one can see a moist, whitish, mucoid material which marks the region of the lower part of the basal cell layer and papillae. This zone is very vascular and fragile. When the lesions are treated surgically, this vascular area must be removed completely or the wart will return. If it is electro-coagulated, a tough basement membrane-like surface is soon reached which is an indication that the wart has been completely destroyed.

Histologically, hyperkeratosis, acanthosis and hypertrophy of the papillae are constant findings.

VERRUCA PLANTARIS

Warts on the soles of the feet are common. Helberg [10] found this in 8.8 per cent of all skin lesions admitted to the dermatology clinic at Finsen Institution, Copenhagen. He reports that females exceeded males by 89 per cent in his series of plantar warts. Sixty-seven per cent of all patients were of school age (6 to 15 years). More warts occurred on the anterior portion of the foot in women than in men. Halberg attributes this preponderance of plantar warts in women to the fact that they wear high heels, which causes three and one-half times more pressure on the anterior part of the foot.

When warts of the foot cause pain, this is a clear indication that too much pressure has been applied at that point and this bespeaks the necessity for orthopedic attention.

Verrucae may be transferred not only from one sole to the other but also from palm to sole. Plantar warts among three brothers who were exchanging their socks was described by Thibierge.[13]

Halberg and Lomholt, in the examination of more than a thousand children in Copenhagen found that 5.2 per cent of the girls were afflicted with warts of the feet, and 10 per cent had verrucae vulgaris of the hands. Of the boys, 3.4 per cent had warts of the feet, while 14.1 per cent had warts of the hands.

Histologically, the warty growth shows considerable acanthosis and hyperkeratosis and, as the result of pressure, the acanthosis has a tendency to produce rete cones that widen out laterally rather than to elongate as seen in verrucae vulgaris.

VERRUCAE PLANAE JUVENILIS (FLAT WARTS)

These slightly elevated lesions occur chiefly on the hands and face, varying in size from pinhead to a split pea. They are yellowish brown, and may remain single or may coalesce to form patches. Histologically, the changes are similar to those of *verruca vulgaris,* but much less pronounced. Involvement is mostly in the epithelium. Early lesions usually show hyperkeratosis. Later, hyperkeratosis becomes more marked, and acantosis is just beginning.

VERRUCA ACUMINATA (CONDYLOMA ACUMINATA)

They may occur about the mouth, vulva and anal regions. The lesions are moist, pink or red, or, when macerated, a dirty grey covered with mucopurulent secretion with an offensive odor. Sometimes a yellowish, brownish crust forms over them. Venereal warts often follow the irritating discharges of gonorrhea or leukorrhea, or may be associated with personal uncleanliness, and consist of warty cauliflower-like growths with villous formation, usually on a narrow base or pedicle. These must not be confused with the condylomata of the secondary stages of syphilis which are moist papules found not only on the genitalia but also on the inner surfaces of the thighs and buttocks. The latter are flat, raised, without a pedicle, and have straight or round sides exuding clear serum teeming with treponemes.

VERRUCA DIGITATA

These occur most frequently on the scalp, face and neck. They are characterized by the presence of several finger-like projections with horny caps grouped on a narrow base.

VERRUCA FILIFORMIS

These occur most frequently on the eyelids and neck. They are small, slender, flexible, thread-like growths covered with smooth and apparently normal epidermis.

PROPHYLAXIS OF WARTS

School children suffering from warts should take care that others are not infected. They should be segregated, as far as it is feasible. Their books, pencils and personal belongings should not be interchanged. In dormitories, they should have their own bathrooms, and should not use the school swimming pools or gymnasium. The infected persons should not tread with bare feet where an uninfected person will step. Care should be taken in the use of towels, bathmats and shoes.

TREATMENT

Active treatment for warts is important for three reasons: (1) For cosmetic purposes; (2) for pain, itching, infection and bleeding; and (3) in the case of senile warts, because of the tendency to undergo malignant degeneration.

The treatment of a wart should not leave a scar. The technic should be as painless as possible, and should not disturb the patient in following his occupation.

Therapeutic methods may be classified as follows: (1) psychic; (2) mechanical removal (surgical or electro-coagulation); (3) chemical; and (4) radiation.

PSYCHIC TREATMENT

Psychic treatment of warts is of two kinds: (1) The psychic treatment is combined with some local application or trauma to the wart. The contact with the tissue fluid in the traumatization is inimical to the warts. It may be that suggestion, in some way, decreases the blood supply to the area of the wart and causes its disappearance. (2) Cures in which the warts are not touched may be explained as follows: nervous impulses may cause functional changes in the walls of blood ves-

sels permitting extravasation of fluid and diapedesis of erythrocytes. Alternations in the walls of the capillaries are functional in character and functional change is subject to suggestive and volitional influences and may be so localized, at least in suggestible persons, that the extravasation takes place in predetermined regions.

Recently a well-known surgeon told me how he cures warts, and it was only because his own warts disappeared that he used this method. In many cases in his practice it was successful. He "buys" the warts from the patient who has them. He must give the patient a coin for the sale to be legitimate. His own warts disappeared in this way, three weeks after he "sold" them; and this is the way they disappear after he "buys" the warts of others. This method is, of course, entirely psychic, for no medicine is used ,and the warts are not touched at all.

SURGICAL TREATMENT

1. *By scalpel removal.* In many long-standing juvenile plantar warts which have become consolidated in the connective tissue and are resistant to drugs, Bickel[4] uses surgical removal. He clips off the warts and to obliterate the hypertrophic papillae, he cauterizes the base with nitric acid, carbolic acid, formalin, trichloracetic, salicylic acid, or with 10 to 20 per cent chromic acid. Occasionally he uses carbon dioxid snow to the hypertrophic papillae. He is cautious about using a cautery because of deforming scars and because an anesthesia must be used. It is to be remembered that ethylchlorid will explode if used as an anesthesia at the same time as the cautery.

Tzanck and Moline[29] use the following method: The plantar wart is anesthetized and the callus is curetted to leave a well cleansed cavity. Powdered potassium permanganate is dusted in to produce hemostasis. A dry dressing is applied. The patient can walk but it is better for him to rest for 24 hours. Surgical removal disables the patient for at least a week.

2. *By electrocoagulation.* According to Karp and Frank,[14] the plantar wart should be anesthetized with 2 per cent procaine and epinephrin (1 to 50,000). The cutting current from a spark gap, high frequency is used. The active loop electrode is thrust into the center of the wart to the depth of six to ten millimeters. With a continuous motion, the loop is rotated 180 degrees on its own axis and then it is withdrawn from the linear opening. No tissue is removed. The wound is again painted with tincture of iodin followed by alcohol and then a dry dressing is applied. The patient keeps the foot dry for two weeks. Dressings are changed on alternate days. At the end of two weeks the patient is instructed to take a foot bath of warm water for 20 minutes immediately before going to the physician's office. The physician removes the superficial crust. This practically finishes the treatment. Three to four weeks are required for complete healing of the wart. The patient continues his vocation from the beginning of the treatment without discomfort.

Eller[8] also recommends electrocoagulation after the wart has been anesthetized. One treatment suffices. If infected, prolonged immersion in a warm antiseptic solution of 1:4000 bichlorid of mercury or 1:2000 potassium permanganate is indicated. He does not use carbon dioxid snow. Eller treats callosities first by prescribing correct shoes. The callus is trimmed and either a 40 per cent salicylic acid paste or bichloracetic acid is applied to the callus, the rest of the skin being protected. Every five to seven days the lesion is shaved with a sharp scalpel and acid reapplied.

Corns may also be treated by correction of the shoe, or they may be removed by scalpel. A more conservative method, says Eller, is to soften the corn with frequent soaks in warm water after which the area is pared with a knife until a punctate hemorrhage appears. This spot is cauterized with trichlorid. Corns may also be successfully removed by the application of 40 per cent salicylic acid plaster over a period of several weeks.

Pecker,[23] after thorough anesthetization, uses a mono-active bipolar instrument. The patient holds the negative electrode. The entire lesion is electrocoagulated.

CHEMICAL TREATMENT (LOCAL)

Fuming nitric acid has long been used in treating warts. It practically always leaves a

scar, at times keloidal in nature, unless used with care. Other chemical caustics used are carbolic acid, formalin, trichloracetic acid and salicylic acid.

For early juvenile warts, while still in the process of growing, Bickel [4] used nitric acid in five cases. Three were favorably influenced, two were unaffected. The wart is touched several times with a pointed glass rod or wooden applicator which has been dipped in nitric acid. Exact work is necessary. In order that recurrences be avoided it is essential to be thorough. To avoid ugly scars, the cauterization must not be too deep. The surrounding skin is protected by adhesive tape with a cut-out hole corresponding to the size and position of the wart. The surrounding skin is also protected with vaseline. Keloids may arise following the cauterization of the area surrounding the warts or after too deep cauterization of the lesions. Two cases were treated with trichloracetic acid with unsatisfactory results. Bickel warns against the use of formalin because of occasional unpleasant reactions, since at the cauterized site and its surrounding area a marked inflammation may be manifested.

In early plantar warts, MacKenna [21] uses a local application of a half drachm of zinc chlorid mixed with enough collodium acid salicylic (1 in 10) to make an ounce. The mixture is applied twice a day. However, many patients say they can not stand the pain of this treatment. A less painful preparation is pyrogallic acid in 30 to 50 per cent unguentum resinae, applied once or twice weekly. This treatment is effective and not painful unless the application is left on the site too long.

McKay [19] uses the following procedure: A sterile 0.1 to 0.3 cc of a 50 per cent solution of urea is injected intracutaneously at the site of each growth. Effort is made to get at the base of the wart, but not far beneath it. He used this in 19 cases, and all 19 warts disappeared in from 5 to 18 days. But in another group, only half the patients were helped. Some required a second injection, some were entirely resistent. When warts were numerous, they appeared more resistent. No plantar warts were treated in this series.

Brown and Erdos-Brown [5] treat warts with local injections of bismuth salicylate in oil, or with bismuth sodium tartrate. While these chemicals were successful, they provoked so much pain that the authors searched for a method of combining a high proportion of soluble bismuth with novocain. They finally found that sodium bismuth thyro-glycolate (as used in treating syphilis) was suitable. This is packaged in three grain ampules. Two cubic centimeters of water (distilled) are added to produce a 30 per cent solution. A dental syringe is used. With 2 cc of novocain, this is mixed with the contents of one ampule of sodium thyro-glycolate. The needle is inserted 1 cm. from the wart and directed to the center of the lesion. The wart disappears in 7 to 14 days. Of 50 verrucae so treated, 46 disappeared; 70 per cent disappeared with one injection. In 24 to 48 hours, in the successful injections, a dark subcutaneous hemorrhagic area is seen on the plateau of the wart. If no dark red area appears, the lesion is reinjected within one week.

CHEMICAL (INTERNAL) TREATMENT

Howard [12] cured a case of juvenile warts with mercury iodid, .016 gram, t.i.d. Hexheimer and Marx [11] report 29 cases treated with arsenic. Twenty-three were cured and distinct improvement occurred in four patients withdrawing from treatment before completion. Loeb [16] treated three patients with juvenile warts with salvarsan, in part intragluteally and in part intravenously. A prompt cure occurred in two cases. Arsenic therapy should be avoided in corpulent young persons because of added gain in weight. Allington [1] gave sulpharsphenamin intramuscularly in the gluteal region. His dosage was 0.1 to 0.3 grams according to age and weight. Control cases were given distilled water. Of those treated with sulpharsphenamin, 52 per cent were cured. But of those treated with distilled water, 47 per cent were also cured.

Some authorities (cited by Bickel [4]) believe that the flat juvenile wart can be treated by *immunotherapy*. The assumption is that in juvenile warts an alteration of the skin has occurred with lowered resistance to the wart virus. Thus it becomes advisable to deprive the

virus of a suitable medium. This is accomplished by the intracutaneous injection of sterile milk by Dietel's method. Fresh milk is sterilized by boiling in a water-bath. Two to four intracutaneous wheals are raised on the extensor side of the forearm. For each wheal a little less than 0.1 cc of milk is injected, twice a week. Reported results may be summarized as follows: Of a total of 39 patients, this technic cured or "almost cured" the lesion in 23 cases, which is about 60 per cent. The number of injections did not seem to make much difference, since of the 9 who had fewer than 6 injections, 5 were influenced favorably (which is 56 per cent) and of those who had 16 to 25 injections, 4 out of 8 (that is 50 per cent) were favorably influenced.

General resistance to warts may also be increased by injection of the patient's blood into the buttocks. The proteins thus injected are foreign in two respects. They are foreign to the structure in which they are placed by injection. Secondly, the blood proteins are not absorbed until they are broken down by enzymes produced in adjacent cells and can enter by diffusion into the blood or lymph stream. The blood of those who had had no warts or were cured of them was also used (Zwick[31]).

RADIATION THERAPY

While many methods of treatment have been presented above, the technic I use most often is roentgen radiation. Most of the other procedures require the preparation and care of a minor operation. Three to six weeks may be necessary for healing and during that time strict asepsis must be maintained. Bandaging is often required. The patient is practically always left with a scar. Furthermore, these methods are impracticable for multiple warts, or warts on the hands of workers. Roentgen treatment, however, is simple, requires only three to five treatments of five to ten minutes each, leaves no scars and does not disrupt the patient's routine.

The *verruca vulgaris* and *plantaris* are the most radio-sensitive. *Verruca seborrheic* and *senila* are not as radio-sensitive as the *verruca vulgaris*. *Verrucae acuminata* and *planis* are still less radio-sensitive, while *verrucae digitata* and *filiformis* are usually not radio-sensitive at all. There is marked variation in radio-sensitivity, depending probably upon a histologic change in the epithelium and papillae. The greater the acanthosis and parakeratosis of the epithelium, the less the hyperkeratosis; and the greater the vascularity and round cell perivascular infiltration, the less the infection, the greater the radio-sensitivity. The closer the epithelium and papillae resemble the normal (for instance in the *verruca digitata* and *filiformis*), the less the radiosensitivity. As a matter of fact, no change occurs in some of these even though they are given doses which destroy the ordinary skin cancer.

Roentgen rays cause warts to disappear for four reasons: (1) Because of the increase in the size of the radiosensitive basal cell layers; (2) because there is also an increase in the cellular elements of the corium, especially the round cells, which are radiosensitive; (3) some warts are highly vascular, which is a factor conducive to radiosensitivity; (4) most warts are caused by a virus, and the virus organism is probably sensitive to x-rays.

Warts sometimes react peculiarly to radiation treatment. Treating one verruca may cause warts on other parts of the body to flatten and disappear in a few days or weeks. Some react to a slight amount of radiation. As a matter of fact, in one of my cases, after treating one member of a family, two relatives who were present in the treatment room also noticed that their warts disappeared in a few days.

Some warts do not disappear with x-ray. These can be treated, however, with electrocoagulation or chemicals.

In the treatment of warts, I use medium and deep roentgen rays. Others have used skin therapy, and even more superficial treatment. The following factors were used with medium deep therapy: 140 Kv, 0.12 to 0.25 mm. cu. and 1 to 3 mm. al. filtration, 40 to 50 cm. distance, 5 to 20 mamp., 300 r. with backscattering per treatment, given weekly, until 900 to 1200 r. have been given. In deep therapy the following factors were used: 200 Kv, 20 mamp, .5 mm. cu. 1 mm. al. filtration, 400 r. units measured with backscattering weekly, until 2000 r. units were given. I protect the normal

skin with lead. Results of treatment are about the same with medium as with deep roentgen treatment. MacKee [20] has used both filtered and unfiltered radiation and in most cases no difference was noted. MacKenna [21] prefers skin radiation filtered with 0.5 mm. al. He gives 900 r. His patients wear white cotton socks which are boiled nightly. The feet are powdered with antiseptic dusting powder.

Belot and Fichgrun [3] believe a characteristic sign of plantar warts is the presence of one or several small black points in the depressed center of the induration. Treatment consists of one massive single dose of 1300 to 1600 international r. units with or without filtration, through 1/10 mm. of al. at 110 Kv. They use a lead shield about the plantar wart, glueing this shield to the skin so that it will not slip. After treatment a felt ring is worn about the area to avoid irritation. They apply no caustics or pastes. A hot foot bath is taken daily and the warts are scraped. These warts are eliminated 25 to 30 days after treatment. They do not believe small successive treatments should be used. If several warts exist, they treat the largest. The others may go spontaneously.

Popp and Olds [22] report the following results with unfiltered radiation at 80 Kv.

Of 91 patients treated:

58 patients, or 63% obtained complete cures.
18 patients, or 19% obtained no benefit whatever.
6 patients were cured by subsequent treatment elsewhere.
6 patients obtained relief of pain only.
3 patients obtained only partial or temporary relief.

In 40 patients, the lesion disappeared in one treatment.
11 patients, the lesion disappeared in two treatments.
5 patients, the lesion disappeared in three treatments.
2 patients, the lesion disappeared in four treatments.

The average time interval between the beginning of the treatment and the disappearance of the lesion was four weeks.

Of the patients who attained a complete cure, in 32 the amount of x-ray used was 2.5 erythema skin doses.

5 patients received 3 ESD
7 patients received 2 ESD
7 patients received .66 to 3 ESD (in 1-3 tr. over period of time)
7 patients received .5 to 2 ESD of radiation filtered with 2 mm. al. at 100 kv in addition to 1-2 ESD of unfiltered radiation at 80 kv.

In 18 patients not benefited:

11 received 2.5 ESD
1 received 3 ESD
4 received .66 ESD to 3 ESD
2 received both unfiltered and filtered radiation as described above.

Factors used by Popp and Olds were as follows: Unfiltered radiation, 80 Kv, 6 m.amp., S.T.D. 16 inches (40 cm.). With these factors a *threshold erythema* is produced in six minutes (400 r). The initial dose is usually 18 minutes (1200 r) using lead foil screen with lesion showing in hole.

RADIUM

MacKee [20] has used radium in some cases of warts on the nostril, at the vermillion border of the lip or at the mucocutaneous junction of the eyelid. Results were excellent with both beta rays and gamma rays, depending upon the size and thickness of the lesion. Small lesions may be treated with penetrating beta rays, especially if most of the horny layer is first removed. A screen of 0.1 mm. of aluminum is sufficient. A half strength, flat, glazed element applicator, screened with 0.1 mm. aluminum, may be placed in contact with the lesions for 15 to 30 minutes or longer, depending upon the thickness of the horny layer. Screened with 1 mm. of brass and 1 mm. aluminum and in contact with the lesion, the exposure will be one or two hours or even longer. A 25 mg. or millicure tube with 1 mm. brass, 0.5 mm. silver, and 1 mm. aluminum, and held ½ inch from the surface, may be applied for 3 to 6 hours.

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316 Broadway

MASKING OF MASTOIDITIS SYMPTOMS BY PENICILLIN

ARTHUR S. WILNER, M.D., Trenton, N. J.

Whether penicillin therapy could cloud or mask symptoms of mastoiditis has long been a subject of controversy. The following case report seems to support the contention that though miraculous cures have been attained by use of pencillin and sulfa drugs, these preparations may sometimes obscure the very symptoms for which the doctor is looking.

A 15-year-old healthy looking male with a history of right aural discharge for two years was taken ill on 14 November 1945 with vertigo, nausea, blurred vision, pain in right ear and inability to keep head erect. After a week of unsuccessful treatment at home, he was admitted to the hospital. Examination revealed a suppurative discharge from the right ear and marginal perforation in the lower posterior quadrant. Tenderness was felt over the right mastoid but there was no swelling. He had a tendency to fall to the left and showed past-pointing to the left. Relief from vertigo and nausea was achieved only when he closed his eyes and tilted his head to the left. Temperature was 101, pulse was 96 and respiration 22. X-ray disclosed marked cloudiness of right mastoid but there was no distinct evidence of necrosis. Blood count revealed 32,000 leukocytes of which 88 per cent were polymorphonuclears. Sedimentation rate was 25. Spinal fluid was not under excessive pressure, Tobey-Ayres test was negative and the spinal fluid itself was chemically and cytologically normal. The ear discharge was cultured and *staphylococcus albus* was identified in the pus.

Penicillin therapy began on 21 November with 30,000 units every three hours intramuscularly and 100,000 units by continuous drip over eight hours intravenously. Intramuscular penicillin was continued and another 100,000 units were given the next day by continuous drip. Sulfadiazine medication was initiated 23 November, being given orally, as by this time he was able to retain fluids. He improved continuously until 1,490,000 units of penicillin were given and in a week he was out of bed and apparently well. Temperature dropped to normal. Aural discharge practically disappeared and only slight moisture could be detected in the perforation. There was no mastoid tenderness. Labyrinthine symptoms disappeared. Medication was stopped.

An operation was advised because of the history of the previous recurrent aural discharge and the possibility of a recurrence of the labyrinthine symptoms. Modified radical mastoidectomy was performed. Operative findings were: empyema of the mastoid cavity, numerous granulations along the sigmoid sinus and mastoid and a large cholesteatoma in the middle ear. The latter was excised. Yellow thick pus was encountered as soon as the cortex was removed. At conclusion of the operation, sulfathiazole powder was placed in the wound and a small drain inserted. Penicillin therapy was resumed, 30,000 units every two hours until 270,000 units had been given. Following an uneventful recovery, the patient was discharged on 17 December 1945. Diagnosis was: Acute exacerbation of a chronic suppurative mastoiditis with perilabyrinthitis.

CONCLUSION

In spite of all the penicillin and sulfadiazine therapy, and regardless of the disappearance of the symptoms, this patient still had a dormant empyema of the mastoid which, if not opened, could have caused disastrous results. It is always advisable to keep patients of this sort under observation for some time after treatment with penicillin or sulfa drugs. There is still no medical cure-all for mastoiditis when surgery is indicated.

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THE TREATMENT OF AMEBIASIS

J. Gerendasy, M.D., Elizabeth, N. J.

The *entameba histolytica* is the most frequently encountered pathogenic intestinal protozoon infesting the human organism. Variability of signs and symptoms is a characteristic of amebic infestation. This is especially true in chronic cases which make up the larger proportion encountered in practice and which are frequently undiagnosed. The term "amebic dysentery" is a misnomer since enteric symptoms are frequently absent.

TYPES

Three well defined groups are recognized:

1. *Acute fulminating amebic colitis,* epidemic and virulent in form, with a high mortality. Usually the source of infection is definitely traceable.

2. *Chronic Amebic Colitis:* An active protracted infectious process, usually of undetermined origin. During its prolonged clinical course, attacks of digestive disorder, bloody diarrhea, loss of weight, anemia and general health impairment will alternate with irregular periods of quiescence. During the latent period, the disease continues to progress and cause serious complications, such as liver abscess.

3. A group of *atypical cases* not showing enteric symptoms. These occur with sufficient frequency to warrant brief description. The following syndromes may suggest this type of amebiasis: inconstant pain in various parts of the abdomen; symptoms of pseudo-appendicitis, severe intractable lumbar or sacral backache, pains in the joints and muscles, low grade daily fever associated with marked physical fatigue (as in tuberculosis), secondary anemia not responding to iron or unexplained massive hemorrhage from the bowel. In these cases, diagnosis depends on finding the pathogenic amebas in the stool or by a therapeutic test.

Some explanation for the inconstant manifestations of this disease may be obtained by reviewing certain etiologic factors:

1. The location of the lesion in the colon and the extent of the involvement varies the clinical picture. For example, amebic infection of the terminal colon and rectum is usually associated with severe diarrhea and the passage of blood and mucus.

2. The more concentrated the invasion of the host, the more virulent the disease.

3. A superimposed bacterial infection may complicate and obscure the infection, giving a syndrome suggestive of chronic ulcerative colitis.

4. The reaction of immunity of the human host to the invasion of the ameba, in this as in other infectious processes, determines the severity of the disease.

5. The changes of morphology which the organisms undergo during their life cycle from the stage of motile trophozoite activity and tissue invasion to the stage of encystment and latency, influence the picture.

DIAGNOSIS

The history of every patient should include a note relating to service or travel in the tropics, especially in the Near East, India and China. This will contribute much toward a diagnosis of this as well as other protozoal infestations.

It should be the rule to investigate thoroughly every case of recurring attacks of diarrhea for protozoal infestation irrespective of the signs and symptoms.

Absolute diagnosis depends on the microscopic finding of *Entameba histolytica* in the feces or tissues. If the stool is solid, search is made for encysted forms. Motile trophozoites are found in liquid tools or may be searched for after a saline cathartic or a high tepid saline enema. The material is selected after the bulk

of the stool or enema has been passed, preferably close to the laboratory to insure a warm specimen for examination. A great deal of uncertainty may be overcome by routine use of the sigmoidoscope in all suspected cases. This may reveal the characteristic ulcerations of the rectal mucosa from which scrapings may be obtained or biopsy of the margin of the ulcer may be used for histologic examination. A warm specimen of loose stool or bloody mucus transferred directly under a microscope may reveal motile amebas without the necessity of a warm stage microscope. The more refined, diagnostic laboratory technics are outside the scope of this paper.

CLINICAL MANAGEMENT

The first problem is the earliest possible eradication of the intestinal infestation to prevent extensive local bowel or systemic injury. Next problem is the elimination of cysts and trophozoites which have already invaded organs such as the liver, lungs or spleen. It is the destruction of the viable organism in the extra-enteric structures which makes the problem of amebiasis so difficult and necessitates repeated courses of treatment to prevent relapses.

The drugs in common use in the treatment of amebiasis are of three types: (1) Alkaloids such as emetin hydrochlorid or emetin bismuth iodid for the acute condition; (2) the organic arsenicals such as carbasone Stovarsol, Treparsol, and (3) the iodin compounds such as diodoquin, vioform and chiniofon (yatren). When many bowel ulcerations are present the iodin compounds are safer than the arsenicals; on the other hand the arsenicals are more efficacious for the encysted or tissue invaders.

Treatment of *acute amebic colitis* with fever, diarrhea and prostration includes bed rest and supportive measures, such as intravenous saline-glucose solutions to overcome dehydration. In severe cases, blood plasma (in adequate doses) is indicated. Hot compresses to the abdomen, a non-residue diet and full doses of tincture of belladonna will relieve intestinal spasm. If there is much pain the bowel is further sedated with deodorated tincture of opium, 10 minims every 4 hours by mouth or via the rectum as an opium suppository. Emetin hydrochlorid is given intramuscularly twice daily in ½ grain doses for 5 or 6 days. Simultaneously capsules of vioform 0.25 grams are administered 3 times a day for 10 days. Enemas of chiniofon 4 grams to 500 cc of water are also given, repeated daily for 7 to 10 days, or until the acute symptoms subside. Precede each retention enema with a cleansing enema of 2 per cent sodium bicarbonate in a pint of warm water. A warning about the use of emetin is necessary, since effective doses lie within toxic range. Emetin Bismuth Iodid, 0.2 gms. in a hard gelatine capsule, by mouth, once daily for 12 days is also recommended. However, it is likewise very toxic and bed rest is essential during its administration.

CHRONIC AMEBIASIS

Hospitalization and bed rest are adjuncts to the treatment. A low residue, high caloric, high protein diet is prescribed as well as a brief course of emetin hydrochlorid, 1 grain daily intramuscularly for 6 days. If only cysts are found in the stool or tissues a course of carbarsone 0.25 grams t.i.d. is given for 10 days. One week later examine stools for cysts on three successive days. Repeat the course using diodoquin 0.6 grams by mouth for 7 days t.i.d. The treatment is repeated if relapses occur or amebas are found. Since the margin between the toxic and therapeutic doses of these drugs is small, the administration must be discontinued at once should toxic signs and symptoms occur. A rest of 2 or 3 weeks between successive courses is advised. Vitamin therapy is indicated here as in all severe cases of diarrhea. Proper isolation should also be practiced.

Persistence in adequate and properly timed administration of these drugs is the keystone to successful treatment.

956 E. Jersey St.

ASYMPTOMATIC CONGENITAL DIAPHRAGMATIC HERNIA

A CASE REPORT

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Congenital diaphragmatic hernia is a rare entity. The fact that this patient is a young woman of 21 in fairly good health with no symptoms justifies the following case report.

Congenital hernias are not as frequent as the acquired or traumatic types, incidence being about one to five. Causes are: (1) A defect in the anlage, (2) failure of union of the anlage, and (3) failure of the development of the whole or half of the diaphragm. These hernias are said to be more frequent on the left than on the right side, in the ratio of ten to one, and males are affected twice as often as females.

In a report by Harrington of 250 cases of diaphragmatic hernias, only four were cases of a right congenital hernia containing small bowel and colon.

Congenital diaphragmatic hernias are attributed to embryologic defect and usually do not have a sac. Sites of congenital hernia in order of frequency are: (1) Through the hiatus pleuro-peritonealis (foramen of Bochdalek); (2) through the oesophageal hiatus; (3) through the anterior substernal opening (Larreys space), and (4) through the gap caused by a partial absence of the diaphragm.

The original body begins to be subdivided when the embryo is about 2 mm. long. The primitive diaphragm is formed by the fusion of the transverse septum, the dorsolateral pleuro-pericardial membranes and parts of the pleuro-peritoneal membranes. The pleuro-peritoneal fold in its growth forms a narrow channel, the pleuro-peritoneal canal, which corresponds with that of the hernial opening. According to Jahn, the intestines begin rotation before the seventh week when the bowel is physiologically herniated into the umbilical region. They return to the peritoneal cavity three weeks after the pleuro-peritoneal foramen is closed. It is therefore to be assumed that the cause of the congenital diaphragmatic hernia is either a premature return of the intestines from the umbilical pocket or a patency of the pleuro-peritoneal opening.

Because of the occurrence of the hernia at birth, respiratory and cardiac symptoms are usually severe due to derangement of intrathoracic pressure and lack of compensatory respiratory and cardiac reserve. Many infants die in their first days or weeks. If cardiac and respiratory mechanisms are able to compensate



for the presence of abdominal contents in the thoracic cavity, these patients may live to adult life without apparent disability, provided no obstructive symptoms develop.

CASE REPORT

C. G., age 21, appearing acutely ill, was admitted to the hospital May 29, 1944, complaining of right side pain and nausea. When she was born (premature six weeks) the mother was told that the child could not possibly live. However, the patient was never seriously ill. Her menstural periods are every 28 to 30 days, last 6-8 days and are rather profuse. She has no complaints of constipation nor of any

other digestive symptoms. She suffers from frequent colds. Repeated chest x-rays and sputum analyses led to no definite diagnosis.

Physical examination shows a slim, fairly well developed young woman in acute distress. Examination of the heart discloses regular sinus rhythm—rate 104 per minute, sounds of good quality, valvular sounds very strong and no murmurs. Lungs are clear to percussion and free of râles. Breathing is shallow and the rate is increased. The right iliac region is tender on palpation with definite rigidity and rebound tenderness. Rectally, a round mass could be palpated about the size of an orange. This mass was tender and movable and there was some fullness of the cul de sac. The urine was amber, cloudy, acid in reaction and free of albumin and sugar. Tentative diagnosis was right ovarian cyst with possible rupture and intraäbdominal bleeding.





At operation, the abdomen was found to contain free blood and blood clots. A right ovarian cyst showing a fresh rent was removed. Exploration of the abdomen revealed a single loop of large bowel extending diagonally across from the rectum to the right hypochondrium and disappearing behind the right lobe of the liver. The stomach was ptotic and the liver enlarged. Patient's recovery was uneventful and her bowels moved on the fourth day with the help of a low oil enema. She was discharged on the twelfth day.

Gross examination shows a cyst the size of an orange. The surface was smooth. On section, the cyst was found to be a large cavity containing blood. Microscopic examination revealed large, follicular cysts in the loosely arranged ovarian stroma, much of which was vascularized.

Examination of the gastro-intestinal tract with the barium meal showed a sthenic type stomach, normal in size, shape, position, tone, contour and peristalsis. The duodenum was large in its first portion, which was elongated and drawn upward. The second portion of the duodenum extended directly upward into the thorax, where the jejenum and ileum also lay. There was rapid initial gastric emptying and a normal progress of the meal through the small intestine at one hour. At five hours, distribution of the barium was slightly retarded.

Examination of the colon with the aid of a barium enema showed a redundant sigmoid extending upward through the central portion of the abdomen and joining the descending colon in the right upper quadrant. The descending colon extended upward into the thoracic cavity which contained the remaining colon with the exception of the caecum. The caecum lay between the axillary portions of the seventh to tenth ribs. No diaphragm was evident on this side. Compressed lung was seen above the second rib. There was no motion of the colon with respiration. The heart was displaced slightly to the left. The left lung was clear. The left leaf of the diaphragm moved normally and was normally placed.

STATE ACTIVITIES

CHARTER READERS OF OUR JOURNAL

This is the 500th issue of the *Journal*. When the first issue appeared in September, 1904, the Society had about a thousand members. Following is a list of the 114 readers of that first Journal who have been with us for all 500 issues:

David B. Ackley
William H. Areson
Maurice Asher
Raymond D. Baker
Samuel H. Baldwin
Clara K. Bartlett
Christopher C. Beling
Joseph V. Bergin
Angelo R. Bianchi
Stella S. Bradford
William M. Brien
Victor E. Bullen
Fletcher M. Carman
J. Franklin Chattin
Joseph G. Coleman
Hugh F. Cook
Alfred Cornwell
David R. Crounse
S. Herbert Culver
Maximillian Danzis
Frederick H. Decker
Henry B. Diverty
Lucius F. Donohoe
Wells P. Eagleton
Linn Emerson
James G. Enright
Harry B. Epstein
Charles H. Finke
Clyde M. Fish
Charles F. Fisler
George W. Fithian
William Flitcroft
Frank Freeland
Richard D. Freeman
George E. Gallaway
Francis H. Glazebrook
Frank S. Gordon
Edward Guion
Willets P. Haines
Frederick S. Hallett
James T. Hanan
Charles W. Harreys
E. Zeh Hawkes
Frank C. Henry
George J. Holmes
J. Edgar Howard
Frederic J. Hughes
Ernest G. Hummell
A. Dunbar Hutchinson
Harry W. Ingling
J. Eugenia Jaques
Meyer Jedel
J. Morgan Jones
Isaac E. Leonard
Horace R. Livengood
Otto Lowy
John L. Lund
William W. MacAlister
Joseph A. Maclay
Charles H. Mayhew
Eugene A. Meachan
Paul M. Mecray
Clinton D. Mendenhall
Paul E. Menk
Emma P. W. Metzer
H. Garrett Miller
Clifford Mills
Augustus J. Mitchell
Charles H. Mitchell
George W. Muttart
Charles B. Neal
William Neer
William Petry
Abdon V. Piskorski
B. S. Pollak
Thomas P. Prout
Charles H. Purdy
Wallace Pyle
Robert C. Ribbans
Emma M. Richardson
John J. Ritter
Robert H. Rogers
Leon T. Salmon
Charles E. Saulsberry
Frank G. Scammell
Charles H. Schlichter
Charles A. Schneider
Charles H. Scribner
Frederick W. Sell
Frederic H. Seward
Milton A. Shangle
Frederick G. Shaul
Elbert S. Sherman
Russell A. Shirrefs
Harry B. Slocum
George N. J. Sommer
Ira T. Spencer
Edwin Steiner
Joseph Stokes
Harold A. Tarbell
Charles E. Teeter
Francis H. Todd
Rolland D. Tomlinson
George T. Tracy
Ernest Tutschulte
George W. Tyrrell
A. B. Vanderbeek
Joseph S. Van Dyke
William L. Vroom
Arthur J. Walscheid
Charles H. Waters
Louis Weiss
Charles W. Wilson
John H. Winslow

NO EXTRA SUGAR FOR PATIENTS

The following represents the considered judgment of the Subcommittee on Medical Food Requirements of the National Research Council:

"Additional rationed sugar, beyond the 15 pounds per capita per year now allocated under current rationing regulations, is not essential in the treatment of any disease, because unrationed sources of carbohydrate, including syrups, preserves and processed fruits and juices, are now readily available to provide a source not only of readily assimilable carbohydrate, but also a wide range of palatable substances calculated to appeal to the palate of individuals, sick and convalescent, whose appetites have been impaired by illness."

THE VETERANS' PLAN

The Veterans' Plan, operated by Medical Service Administration, providing payment for care rendered veterans for "service-connected" disabilities, has been in operation since March 15.

As in any new venture, defects and difficulties have presented themselves which will require the indulgence of all concerned until a solution can be evolved.

I. The Size of the Load

As anticipated, the load is heavy, too heavy to be handled efficiently, until Medical Service Administration office expands and trains new personnel. At this writing (April 1, 1946) four clerks have been added to the staff and are becoming efficient in the work. Other clerks will be added to the force. At present Medical Service Administration is processing about 150 cases a day, but a backlog of about 1,500 cases has accumulated in the office. Additional office space in another building has been procured which will allow for expansion of personnel sufficient to handle the load.

II. Making Service Available to Veteran

Authority to treat a veteran is required in each new case. It is not the function of Medical Service Administration to assist in obtaining this authority. It should be obtained by the veteran from Veterans Administration. However, the demand upon Medical Service Administration by physicians and veterans for assistance has been so heavy that we have had the required forms printed and requested Veterans Administration to distribute the forms and a letter of instruction to each Veterans Administration office in the state, all American Legion offices and all Red Cross Chapter offices. When this *Journal* reaches you, the above arrangement should have been accomplished and you may refer a veteran to any one of those agencies in his community for the necessary forms.

III. Unauthorized Services

Every day Medical Service Administration receives bills from physicians for services which have not been authorized. These services range all the way from an office visit to major surgical procedures. Many of the services were rendered weeks ago. Such services cannot be paid for by Veterans Administration. You must, in new cases, file a "request for authority" within five days of the time the treatment is rendered. This is a decision of the comptroller general which must be adhered to by Veterans Administration. Remember also that all eligible service must be "service connected". The individual physician can usually judge whether or not the condition is service connected, but officially the Veterans Administration is the only agency that can make this determination.

IV. Hospitalization

"Authority for Hospitalization" is required on each case you admit to hospital. At present, we advise that when you have such a case, you or your Hospital Director contact Veterans Administration at Lyons, New Jersey. The telephone number is Millington 7-0180. Ask for Dr. Rainone. Inform him of the name of the hospital. name of patient, diagnosis and the daily hospital cost. If the cost is reasonable, and the case is, or is presumptively, service connected, he will authorize the hospitalization by telephone and confirm it later in writing.

Medical Service Administration contemplates making contact with hospitals for the hospitalization incident to the medical plan. To accomplish this it was necessary to amend the enabling act of Medical Service Administration. A bill to amend the Act has been introduced in the State Legislature. It passed the Senate on March 25. When this Bill is signed by the Governor, Medical Service Administration will proceed to evolve the hospital phase of the program.

In the meantime we request your indulgence until such time as our many problems are solved and the Plan is operating smoothly.

Norman M. Scott, M.D., Medical Director,

Medical Service Administration.

COUNCIL ON MEDICAL SERVICE AND PUBLIC RELATIONS

Regional Meeting — Philadelphia, Jan. 31, 1946

The Conference was well attended and our Society was represented by the following: President Alexander, Dr. Sica, Chairman of the Public Relations Committee; Dr. Pollak and Dr. Quigley, Chairman and Executive Secretary respectively of the Committee on Legislation, and Dr. N. M. Scott, Medical Director of Medical Service Administration.

The first matter considered was the character and scope of future conferences. It was the consensus that these conferences should be the avenue for a two-way flow of ideas and problems from the American Medical Association, particularly from the Council on Medical Service and Public Relations, and from the delegates of the several states composing the conference, on matters which the states feel should engage the attention of the Council on Medical Service and Public Relations. To effect this a committee was appointed by the Chairman, Dr. Borzell, to make recommendations at the next meeting of the conference which is scheduled for May 9th.

The remainder of the morning session was devoted to medical service plans and their progress in the several states. Mr. Ketchem, Executive Director of the Michigan Medical Surgical Plan, presented a comprehensive paper discussing the advantages and disadvantages of medical services vs. indemnity plans. He discussed coördination with Blue Cross plans, and also expansion of medical service plans to other states, and how the present advisory committee to the Council on Medical Service and Public Relations could be utilized.

The various states reported on medical insurance plans as follows:

New York—Now has six plans in operation with 265,000 enrolled.

Virginia—At present no plan, but about ready to place one in operation.

District of Columbia—Expects to report to the District of Columbia Medical Society a limited service plan, no income level, but using as eligible those who are entitled to semi-private hospital care.

Maryland—In process of starting a plan—the necessary legislation has been passed.

New Jersey—The various plans now in operation were described quite fully by Dr. Scott, who also outlined the contract between the Medical Service Administration of New Jersey and the Veterans Administration, the only such contract in the East.

Pennsylvania—Reported progress and an endeavor to coöperate with Blue Cross plans, utilizing this organization in selling subscriptions, but keeping medical service administration separate and under the control of the Society.

At the afternoon session, Mr. Hendricks, Secretary of the Council on Medical Service and Public Relations, reported on:

1. The action of the House of Delegates as to prepayment plans, relative to coördination between the states and the expected aid that will be given by the Council.
2. The Fourteen-Point Program of the A. M. A.
3. Public Health Clinics: their set-up and means test for beneficiaries of maternal and child health care.
4. National Health Congress.
5. The need for information bureaus in the various states.
6. A fact finding committee of the Council to study means of better coördinating the activities of the several committees and bureaus of the A. M. A. with those of the Council.

Colonel Harding, representing General Hawley, Medical Director of the Veterans Administration, outlined the plans for medical care of veterans. The outline was similar to that which he presented at the last meeting of our Welfare Committee.

Representatives of the Pennsylvania Society, including the Secretary, Dr. Walter Donaldson, discussed public relations programs of State Societies. He described health programs carried by newspapers, especially weekly newspapers, and graphically illustrated other phases of the program by moving pictures.

STUDY OF CHILD HEALTH SERVICES

All New Jersey physicians who in any way care for children, are being asked to fill out a questionnaire as part of the Study of Child Health Services in New Jersey. This project is being conducted by the American Academy of Pediatrics throughout the country. It has the full approval of our State Medical Society, and arose from the realization that if children are to have the care they need in the postwar era, thorough planning is necessary.

Besides the data collected from practitioners, detailed information on pediatric care will be sought from all hospitals, sanatoria, child health conferences, school-health services,

child-guidance clinics and public health nursing. One purpose of the study is to stimulate local groups to discover for themselves the needs within their own communities, and to evaluate existing facilities.

The Coit-Memorial-Babies Hospital in Newark has donated office space, and the Roche Anniversary Foundation of New Jersey has offered financial assistance. We have been assured of the coöperation of the Bureau of Maternal and Child Health and various State Agencies.

At the conclusion of the study a report will be prepared which will be available to all, and will be used as a basis upon which recommendations for medical care programs for children can be made. It is important that we undertake this task. Various bills now before Congress indicate that unless we make this survey, others less qualified than we are will conduct it.

Harrold A. Murray, Chairman,

Child Health Committee.

INSURANCE AGAINST UNEMPLOYMENT BECAUSE OF SICKNESS

Last month a bill was drawn up by Assemblyman Huhn of Essex which would provide for cash benefits (probable maximum $22 a week) for not more than thirteen weeks a year during periods of unemployment due to illness, not covered by Workmen's Compensation. Background of the bill is this. Under present unemployment insurance practice, an employee can not draw anything from that fund if his unemployment is due to illness, since it is required that he be willing and *able* to work before he can claim benefits. Since part of the fund is made up of employee contributions, this leaves the sick worker in the position of being unable to get back even his own money if he is out of work through illness. To fill this gap, Mr. Huhn had drawn up Assembly Concurrent Resolution No. 3 which directs the State Commission on Postwar Economic Welfare "to make a study of the establishment of an Unemployment Sickness Compensation Fund" and which embodies a tentative draft of appropriate legislation. The bill in essence has these provisions. It sets up an "Unemployment Sickness Compensation Fund" made up of the money paid by employees under present social security laws and permits workers in insurance-covered jobs to draw on this fund (after a one-week waiting period) in the event that they are unemployed by reason of noncompensable accidents or illnesses. Pregnancy is excluded in the present form of the proposed bill. Employers who have a "sound sickness benefit plan meeting the requirements of the act, may upon proof and certificate, be exempted from the provisions of the act."

The principle of cash benefits to workers, unemployed because of illness, was endorsed by the Legislative Committee of The Medical Society of New Jersey. Dr. Frederic J. Quigley, Executive Secretary of that committee, read a statement to the Postwar Economic Welfare Commission on March 8, an abstract of which follows:

"The Medical Society of New Jersey endorses in principle cash sickness benefits to compensate partly for loss of wages due to unemployment caused by sickness. . . . Such provisions are of especial interest to the medical professions because of their health implications. The House of Delegates of the American Medical Association, as far back as 1938, endorsed compensation for loss of wages during sickness with the comment that 'this principle has distinct influence towards recovery and tends to reduce permanent disability'.

"Organized Medicine favors voluntary programs to meet desirable social improvements wherever such means are feasible. It is our opinion that industry should make available to employees a plan, preferably coöperative, with full use of voluntary plans now in effect. Such a plan should be compulsory only to the same extent that workmen's compensation insurance is compulsory.

"If a waiting period is required before commencement of benefits and if cash benefits are not too generous, the incentive for abuse through malingering would be minimized. If such limitations were not provided and if the Act then placed responsibility for certification of illness and recovery on the attending physician, it would place the medcial profession in a most unenviable position. Certification, however, should be made only by a physician licensed to practice medicine and surgery in this state. Sick employees who choose to be treated by religious healers, mental healers or other cultists should not participate in benefits under this plan. We urge that the counsel and advice of The Medical Society of New Jersey be sought as to the medical features of the bill."

Cash sickness benefits in principle were endorsed by the State Federation of Labor, the State Chamber of Commerce and The Medical Society of New Jersey. It was opposed by the representative of the State Association of Manufacturers. To give our readers a well-rounded picture of the proposed legislation the arguments pro and con are abstracted below.

The representative of the State Association of Manufacturers stated (in abstract):

The State Association of Manufacturers opposes this further encroachment of the state into private enterprise. The Association does not challenge the principle involved but sees no urgent need for the state to engage in such activities. This is not a proposal to prevent illness; it is a project to subsidize illness. The bill does not provide that any of the funds be expended to pay for medical care. It makes the employers the penalty-threatened agency for the collection of more taxes. Let the state be its own tax-collector. Nothing in the bill prevents payments to workers whose illness is due to their own intemperate habits, to family quarrels or to wilful self-exposure to accident. It is a form of subsidized indolence.

The representative of the State Federation of Labor stated (in abstract):

For four years our Association has been seeking such legislation. By now everyone seems to agree to the principle but there is some dispute as to the details. Let us not wait too long to iron out details. Now is the time to start accumulating a reserve fund on which we can draw when the bill is finally enacted in its finished form. New Jersey has already sent some sixty million dollars of social security contributions to Washington which we could keep and utilize in this state if we had adequate legislation. In passing this enabling act, it is important to provide for adequate administration. Poor administration will result in excessive drainage from the pool of funds. The Federation opposes the exclusion of pregnancy from benefit-eligibility since the effect will be to encourage a pregnant woman to work to the last minute, a practice which is detrimental to both maternal and child health. The Federation also opposes the exemption of employers with plans of their own unless more specific standards are laid down.

The representative of the State Chamber of Commerce stated that his organization endorsed the principle of the bill but wanted the funds to come from employers as well as employees. The Chamber also opposed a state monopoly for writing this kind of insurance and believed that voluntary insurance plans should be encouraged. In supporting this, the Chamber of Commerce representative stated, in abstract:

Rhode Island has a government-operated plan similar to the proposal embodied in ACR 3. It was their experience in both 1944 and 1945 that monthly benefit payments were greatest during the summer months, though normally illness has its greatest incidence during the winter. On the other hand, the five-year experience of two large New Jersey private insurance carriers which have voluntarily established benefit programs for their employees, shows that greatest benefits were paid for disabilities occurring in the period from November to March.

A spokesman for a group of insurance companies which, in the aggregate, were writing 95 per cent of all the life insurance in New Jersey, confirmed the observation of the State Chamber of Commerce that under government-operated plans, the greatest apparent idleness due to illness appears to occur during the summer rather than during the winter when sickness is actually more prevalent.

NUTRITION IN EVERYDAY PRACTICE

S. WILLIAM KALB, M.D., Newark, N. J.

Nutrition Representative, Tuberculosis and Adult Disease Control Advisory Committee to the Subcommittee on Public Health

1. *Will President Truman's decision to send foodstuffs to Europe have any harmful effect on our nutrition at home?*

   No, there will be sufficient for us since we need only 93 grams of protein daily. We will also have minerals such as calcium, phosphorus, iron and iodine along with vitamins and additional calories. These can be secured from the following basic seven groups: (1) Green and yellow vegetables; (2) oranges, tomatoes and grapefruit; (3) potatoes and other vegetables and fruits; (4) milk and milk products; (5) meat, poultry, fish or eggs; (6) bread, flour and cereals, and (7) butter or fortified margarine.

2. *Should a single vitamin be used in large doses?*

   Caution must be observed to avoid secondary deficiencies by excessive dosing with one vitamin. Too often we get a vitamin imbalance which was not present in the original condition. The specific or augmented dose of the indicated vitamin should be used in conjunction with moderate doses of the other vitamins related to the one primarily needed. This is especially important in using the factors of the B complex.

3. *Does cirrhosis of the liver have a nutritional background and how is it treated?*

   It has never been definitely established that this condition is primarily a nutritional

disease. The pathology in cirrhosis results in anorexia which leads to malnutrition. For treatment, use choline chloride, 1 to 2 gm. daily, with a diet high in protein and carbohydrate, and low in fat.

4. *What foods can be used to keep up nutrition in patients following tonsillectomies, tooth extraction, or broken jaws?*

   Where swelling or mastication is difficult, a soft diet consisting of pot cheese, eggs, milk, strained vegetables, strained fruits (baby foods), soup and custard may be used conveniently.

5. *Which food supplies the daily requirements of amino acids?*

   Milk meets the optimal daily requirements for all essential amino acids by more than 100 per cent, while meat contains a lessened amount of valine and tyrosine.

6. *How much protein per day is necessary for good nutrition?*

Children:
- 1 year of age, 3 or 4 gms. per kilo of body weight
- 1 to 3 years, 40 gms. daily
- 4 to 6 years, 50 gms. daily
- 7 to 9 years, 60 gms. daily
- 10 to 12 years, 70 gms. daily

Boys:
- 13 to 15 years, 85 gms. daily
- 16 to 20 years, 100 gms. daily

Girls:
- 13 to 15 years, 80 gms. daily
- 16 to 20 years, 75 gms. daily

Men:
- Regardless of activity, 70 gms. daily

Women:
- Regardless of activity, 70 gms. daily
- Pregnant, 85 gms. daily
- Lactation, 100 gms. daily

WITH NEW JERSEY MEDICAL AUTHORS

Compiled by Mildred V. Naylor, Librarian, Academy of Medicine

It is requested that any New Jersey physician who publishes an article outside the state, notify the Editorial Office in Trenton, giving the title of the paper and the name of the periodical, as well as the month, date, volume and page number. It would also be helpful to this office if members would notify us of articles published by their colleagues.

Bechet, Paul E.—Elizabeth
Induced sensitivity from the topical use of the sulfonamides and penicillin. Pennsylvania M. J. 49: 417, Jan. 1946

Bonnet, W. Laurence—Mercerville
Diagnosis of pes planus by x-ray. Radiology 46: 35-34, Jan. 1946

Chesley, Leon C.—see Cosgrove, S. A.

Clark, Dorothy M.—see Smith, Dorothy G.

Cosgrove, S. A., and Leon C. Chesley—Jersey City
Management and treatment of the late toxemias of pregnancy. Am. J. Obst. & Gynec. 51: 67-74, Jan. 1946

Donovick, Richard; Dorothy Hamre, Frederick Kavanagh and Geoffrey Rake—New Brunswick (Squibb)
Broth dilution method of assaying streptothricin and streptomycin. J. Bact. 50: 623-628, Dec. 1945

Eigen, Louis A.—West Orange (in service)
Thrombosis of the basilic, axillary and subclavian veins, of undetermined origin. J. Med. Soc. New Jersey 43: 45-49, Feb. 1946

Gerendasy, J.—Elizabeth
Treatment of the diarrheas. J. Med. Soc. New Jersey 43: 50-51, Feb. 1946

Hamre, Dorothy—see Donovick, Richard

Goldstein, Hyman I.—Camden
Use of methenamine in dermatology. Arch. Derm. & Syph. 52: 185, Sept. 1945

Kavanagh, Frederick—see Donovick, Richard

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Analysis of colds in industry. J. Med. S. New Jersey 43: 49, Feb. 1946

Knight, Richard vanD.—Summit
Puerperal sterilization. Am. J. Obst. & Gynec. 51: 104-108, Jan. 1946
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Kornfeld, Werner—East Orange
Mental deficiency and other psychopathic conditions in early childhood. Med. World, Jan. 1946

Leathem, J., and A. E. Rakoff—New Brunswick
Are antihormones formed during pregnancy. Am. J. Obst. & Gynec. 51: 97-99, Jan. 1946

Levine, Philip, and R. K. Waller—Linden
Erythroblastosis fetalis in the first-born. Blood 1: 143-155, Mar. 1946

Lewis, Leon—Newark (in service)
Industrial mercury poisoning. J. M. Soc. New Jersey 43: 52, Feb. 1946

Peer, Lyndon A.—Newark
Neglected septal cartilage graft (with experimental observations on the growth of human cartilage grafts). Arch. Otolaryng. 42: 384-396, Nov.-Dec. 1945

Potter, Ellen C.—Trenton
Chronic disease challenges the profession. Trained Nurse & Hosp. Rev. 116: 17-19, Jan. 1946
State responsibility for the care of the chronically ill. State Government 19: 39-42 & 61, Feb. 1946

Rados, Andrew—Newark
Occurrence of glioma of retina and brain in collateral lines in the same family. Arch. Ophthal. 35: 1-12, Jan. 1946

RAKE, GEOFFREY—see Donovick, Richard

RAKOFF, A. E.—see Leathem, J. H.

ROBINSON, HARRY J.—see Smith, Dorothy G.

SCHNEIDER, RICHARD C.—Newark (in service) (with others)
Observations on early type of brain abscess following penetrating wounds of the brain. J. Neurosurg. 3: 7-13, Jan. 1946

SHANE, SYLVAN M.—Camden
Needle shield for continuous spinal anesthesia during labor and delivery. Am. J. Obst. & Gynec. 51: 283-84, Feb. 1946

SMITH, DOROTHY G., and HARRY J. ROBINSON, with the technical assistance of Dorothy M. Clark—Rahway (Merck)
Influence of streptomycin and streptothricin on the intestinal flora of mice. J. Bact. 50: 613-21, Dec. 1945

STARKEY, ROBERT L.—New Brunswick (New Jersey Agricultural Station)
Lipid production by a soil yeast. J. Bact. 51: 33-50, Jan. 1946

STERN, MORTON M.—Newark (with others)
Effect of blood myasthenia gravis patients on acetycholine sensitivity of prostigminized frog and leech muscle. Proc. Soc. Exper. Biol. & Med. 54: 181-83, Apr. 1945

VREELAND, RALPH J.—Paterson
Two cases of ozena cured by pickrell solution. J. M. Soc. New Jersey 43: 52, Feb. 1943

WALLER, R. K.—see Levine, Philip

WATERS, EDWARD G.—Jersey City
Presacral sympathectomy for intractable functional uterine pain. Am. J. Obst. & Gynec. 51: 235-40, Feb. 1946

SUPPLEMENTARY LIST NO. 1 TO THE OFFICIAL LIST OF MEMBERS OF MARCH 1, 1946

Abrams, Benjamin P., 9209 Boulevard, N. Bergen (9)
Albrecht, William J., 46 Grove st., Somerville (18)
Aronoff, Herman L., 500a Ocean av., Jersey City (9)
Atwell, David R., 920 Hudson st., Hoboken (9)
Axinn, Charles, 146 W. Gibbons st., Linden (20)
Behrens, Herman, 312 Webster av., Jersey City (9)
Bennett, Lewis T., Federal Shipb'ld'g Co.,Kearny(9)
Berger, Harold R., 250 Elizabeth av., Elizabeth (20)
Boland, Lucy E., 27 Washington av., Arlington (9)
Carr, Alexander M., S. Main st., Metuchen (12)
Carr, Mary, 1 Astor pl., Jersey City (9)
Catlaw, J. Kenneth, 254 Montgomery st., Jer.City(9)
Cohen, Harry X., 1243 Stuyvesant av., Union (20)
Conroy, John S., 124 E. Broad st., Burlington (3)
Conti, Michael, 280 Fourth st., Jersey City (9)
Corwin, Emanuel M., 5 Richards av., Dover (14)
Csema, Emery J., 151 Somerset st., New Brunswick(12)
dePons, Sarah C., 501 Grand av., Asbury Park (13)
Dewis, Edwin, 21 Westra st., Interlaken (13)
Dimitrow, Helen, 161 Broad st., Red Bank (13)
Dolganos, Moses, 268 Palisade av., Jersey City (9)
Donovan, Joseph, N.J. State Hosp.,GreystonePk.(14)
Doody, William M., 19 Bentley av., Jersey City (9)
Dren, George W., 191 Lexington av., Passaic (16)
Fauquier, Leonard B., 172 Jewett av., Jersey City (9)
Fineberg, Jacob C., 50 Glenwood av., Jersey City (9)
Fisher, James A., 501 Grand av., Asbury Park (13)
Frieman, Hyman, 744 Avenue C, Bayonne (9)
Frisch, Edward H. F., N. J. State Vil.,Skillman(18)
Frutig, Harold C., 508 80th st., North Bergen (9)
Gianni, Francis F., Veterans Admin., Lyons (18)
Glass, George A., E. Main st., Somerville (18)
Gnassi, Angelo M., 130 Wegman P'kway, Jer.City(9)
Goldowsky, Ira, 23 Warner av., Jersey City (9)
Gurland, Benjamin B., 146 W. 37th st., Bayonne (9)
Higgins, Thomas A., 2616 Boulevard, Jersey City(9)
Hoffman, Charles W., 226 David st., S. Amboy (12)
Kanengiser, Clifford H., 26 Gifford av., Jer. City (9)
Klein, Allan, 8628 Boulevard, North Bergen (9)
Koppel, Joseph A., 42 Highland av., Jersey City (9)
Leonard, Bernard F., 33 W. Union st., Burlington (3)
Leonard, Lothair L., 615 Asbury av., Asbury Pk.(13)
Lintz, Sidney Z., 525 Kings Highway,Swedesboro(8)
Little, Alonzo W., 120 Arlington av., Jersey City (9)
Loori, William A., 549 Pavonia av., Jesey City (9)
Lovett, Irving, 110 E. Front st., Red Bank (13)
Manly, Thomas E., 390 Park av., Paterson (16)
Matera, Joseph, 506 Garden st., Hoboken (9)
Matturri, Dominick A., 81 Gifford av., JerseyCity(9)
McCarthy, Cornelius P., 887 Boulevard, Bayonne (9)
Metzger, Karl F., 401 Fifth av., Belmar (13)
Moon, Dabney von K., 706 Park av., Plainfield (20)
Murphy, Patrick H. W., 27 Jefferson av.,Jer.City(9)
Nelson, Harry, 36 Lupton av., Woodbury (8)
Nevius, John K., Jr., 1165 Park av., Plainfield (20)
Oesterreicher, Desider, 427 Bergen av.,JerseyCity(9)
Parker, James W., 175 Shrewsbury av.,RedBank(13)
Phelan, Walter F., 124 Chilton st., Elizabeth (20)
Pollak, Berthold S., 100 Clifton pl., Jersey City (9)
Povalski, Alexander W. T., 1925 Blvd., Jer. City (9)
Quaglieri, Charles, 733 Park av., Hoboken (9)
Raso, Frank L., 1218 Central av., Union City (9)
Reed, Robert R., 65 Washington st., Morristown (14)
Reynolds, George G., 64 W. Main st., Freehold (13)
Richardson, Emma M., 581 Stevens st., Camden (4)
Richlin, Padie, 316 George st., New Brunswick (12)
Riese, Jacob A., 6012 Palisade av., W. New York (9)
Schwartz, Leo, 301 Harrison st., Passaic (16)
Shapiro, Edward, 750 Avenue C, Bayonne (9)
Shapiro, Nathaniel J., 212 Palisade av.,UnionCity(9)
Sheeran, Vincent J., 101 Bentley av., Jersey City (9)
Stark, Harry L., 680 Boulevard, Bayonne (9)
Street, Daniel B., 27 Woodlawn av., Jersey City (9)
Teschner, Bernard, 4808 Berg'nline av.,UnionCity(9)
Thomas, Harry G., 1113 Fifth av., Asbury Park (13)
Thomas, Ralph B., 793 Montgomery st., Jer. City(9)
Tidwell, Harold F., 229 60th st., West New York (9)
Upham, Helen F., 305 Third av., Asbury Park (13)
Von Oehsen, Wm., 623 Fourth av.,BradleyBeach(13)
Washburn, Philip C., N.J.StateHosp.,Gr'st'nePk.(14)
Whitcher, Burr R., 214 High st., Mount Holly (3)
Wood, Oram R., 128 W. Broad st., Paulsboro (8)
Zbar, J. E., 2690 Boulevard, Jersey City (9)
Zirpolo, Gene A. V., 1128 Bryant st., Rahway (20)

ANNUAL MEETING — ADVANCE NOTICE

All the activities of your medical society through this year of war and peace come to focus next month with the 180th Annual Meeting of The Medical Society of New Jersey on May 21, 22 and 23 at the Hotel Claridge in Atlantic City. Highlight of the session will be an address by Major-General Paul R. Hawley, Medical Director of the Veterans Administration, who will be principal speaker at the big banquet on Wednesday evening, May 22. Toastmaster on that occasion will be Dr. Hilton Reed.

At the General Session, Tuesday afternoon, May 21, principal speakers will be Dr. Perrin H. Long, Professor of Preventive Medicine at Johns Hopkins University, who will talk on *Medical Progress and Medical Education During the War;* and Dr. Howard A. Rusk, whose topic will be *The Third Phase of Medical Care.* On Thursday morning, May 23, Dr. Cornelius P. Rhoads, Director of the Memorial Hospital in New York, will speak on *Recent Advances in Cancer Research.* Dr. William Bryant Rawls of New York will talk on *Medical Economics Today and Tomorrow* at the same session.

Details of the scientific section programs will be mailed in advance to each member. Sections on Medicine, Radiology, Obstetrics and Eye-Ear-Nose-and-Throat will meet on Wednesday morning and Sections on Surgery, Pediatrics and Gastro-Enterology and Proctology will assemble on Wednesday afternoon. Topics to be covered at these programs are as follows:

MEDICINE

Talks on (a) emotional problems of the veteran, (b) reducing cardiac mortality and (c) treatment of relapsing tropical diseases.

EYE, EAR, NOSE, THROAT

Symposium on (a) Aural rehabilitation, (b) Recent advances in ocular therapy and (c) War casualties in an Army eye center.

RADIOLOGY

Illustrated presentation of the problem of congenital obstructions in the newborn.

OBSTETRICS AND GYNECOLOGY

(a) Management of premature labor. (b) Reduction of maternal mortality. (c) Protection of newborn infants. (d) Obstetrical anesthesia and analgesia.

SURGERY

Papers on: (a) Carcinoma of the rectum, (b) Thrombophlebitis and pulmonary embolism and (c) Surgical treatment of hypertension.

PEDIATRICS

Session will be devoted to a panel-discussion on rheumatic fever with special presentations on heart disease, the school health program, and state and community projects for the control of rheumatic fever.

GASTRO-ENTEROLOGY AND PROCTOLOGY

Papers on (a) intestinal parasitism, (b) common ano-rectal conditions, (c) esophageal hiatus hernia and (d) ulcer therapy.

Speakers at Section Meetings

MEDICINE

Joseph C. Yaskin, M.D.
William D. Stroud, M.D.
Edgar A. Lawrence, M.D.

OBSTETRICS

John C. Hirst, M.D.
Charles A. Weymuller, M.D.
Robert A. MacKenzie, M.D.
James F. Norton, M.D.

EYE, EAR, NOSE, THROAT

Irving Leopold, M.D.
M. E. Randolph, Lt. Col., M.C., A.U.S.
Eva Thompson, Lt., M.C., U.S.N.
Margaret Paul, Lt. M.C., U.S.N.
W. G. Hardy, Lt., M.C., U.S.N.
Frederick Harbert, Captain, M.C., A.U.S.

SURGERY

Reginald H. Smithwick, M.D.
Damon B. Pfeiffer, M.D.
Robert R. Linton, M.D.

PEDIATRICS

William D. Stroud, M.D.
George M. Wheatley, M.D.
J. G. Fred Hiss, M.D.
Betty Huse, M.D.

GASTRO-ENTEROLOGY AND PROCTOLOGY

Frank W. Co-Tui, M.D.
J. L. Mathesheimer, M.D.
Manfred Kraemer, M.D.
Louis C. Perkel, M.D.

RADIOLOGY

John P. Caffey, M.D.

OBITUARIES

DR. KENNETH R. BAUMAN

Dr. Kenneth R. Bauman, chief of surgery at the Millville Hospital, died following an operation there on March 6, 1946. A native of Elmira, N. Y., Dr. Bauman spent most of his childhood in Atlantic City and was educated at the University of Pennsylvania Medical School. Prior to entering medical school he was a student at Pennsylvania State College where he won distinction in football. He interned at the Newark City Hospital and in 1938 moved to Millville where he entered private practice.

ALVAH W. BICKNER

The untimely death of Dr. Alvah Bickner has just been announced. Dr. Bickner served in the First World War, having enlisted at the age of 19. On his return from service, he went to the University of West Virginia and then to the Medical College of the University of Virginia from which he graduated in 1924. After an internship at the Jersey City Medical Center, he returned to Rutherford, his home town, to engage in private practice. He was active in the Lions Club and in the American Legion and also in the affairs of St. Mary's Church. Dr. Bickner was on the Senior Staff of St. Mary's Hospital in Passaic. His wife, Mrs. Eleanor Bickner, has been an active member of the Woman's Auxiliary to the Bergen County Medical Society.

DR. DON AGARD EPLER

The last of four generations of medical practitioners, Dr. Don Agard Epler died in Newark on March 4, 1946. Dr. Epler was born in Cleveland in 1879 and moved to Saratoga Springs, N. Y., in childhood. He volunteered for service in the Spanish-American War and on his return from the Army attended the College of Physicians and Surgeons of Columbia University, from which he was graduated in 1903. He won an internship at the Newark Memorial Hospital the following year and entered private practice in Newark in 1904.

Dr. Epler was on the staff of City, Presbyterian and Lincoln Hospitals in Newark.

He is survived by his wife, Betty, who has long been active in the Woman's Auxiliary and who was president of the Essex County Auxiliary in 1934-1935 and of the State Auxiliary in 1938-1939.

MICHAEL J. KAUFMAN

The Essex County medical profession lost one of its colorful figures on March 23, 1946, with the death on that day of Dr. M. J. Kaufman. Born in Russia in 1882, Dr. Kaufman moved to Germany in 1912 where he entered the medical school of the University of Berlin. Receiving his M.D. degree in 1916, he returned to the Ukraine to engage in private practice for seven years, and came to this country in 1926. Dr. Kaufman was active in literary and cultural circles, and his wife was the daughter of Sholom Alechem, the distinguished Yiddish author. He was on the staff of the Newark Beth Israel Hospital and had served the War Department as an induction station examiner since 1943.

DR. CHARLES J. LARKEY

Dr. Charles J. Larkey, health officer of the city of Bayonne since 1938, died at the age of 63 on February 17, 1946. Born in Newark, Dr. Larkey was graduated from Bellevue Medical College in 1904 and has been practicing in Bayonne since 1906. He has served as a member of the Board of Education and as chief medical inspector of the school system of Bayonne. He was an instructor in radiology at Columbia University from 1933 to 1938. Dr. Larkey was the founder of the Bayonne Civic League and a director of the Bayonne Hospital.

SAMUEL A. MUTA

Dr. Samuel A. Muta, Mayor of West Orange from 1911 to 1914, and a member of the Essex County Medical Society since 1906, died at the age of 64 at his home on March 20, 1946. Born in Bridgeton, N. J., he was graduated from the Jefferson Medical College in 1904, and went to St. Mary's Hospital in Orange for his interneship. He elected to remain in Essex County, and opened an office in West Orange in 1906. Dr. Muta was always interested in civic and fraternal affairs. Prior to his election as Mayor of West Orange, he served as deputy county physician. Later he was Exalted Ruler of the Orange Lodge of Elks, and was active in the Masons and in the Knights Templar. During the recent war, Dr. Muta was head of the medical division of the West Orange Civilian Defense Council.

DR. JOHN ADAM ZUCK

Dr. John Adam Zuck of Netcong died of a heart ailment at his home on February 6, 1946. Dr. Zuck originally practiced in Pennsylvania and moved to New Jersey in 1934. He was graduated from the University of Pittsburgh Medical School in 1923 and served his internship in the Allegheny General Hospital. He was a member of the Morris County Medical Society and of the examining team of the district draft board.

THE BULLETIN BOARD

Doctors alive to the historical and cultural aspects of their profession are advised that a *Journal of the History of Medicine* is now available. Issue number 1, just off the press, is probably the finest sample of typography in American medical journalism. The articles are well-written and well-illustrated and cover in varying detail many interesting sidelights of medical history. Annual subscription to this quarterly is $7.50. Subscriptions and manuscripts should be sent to the *Journal of the History of Medicine* at 20 East 70th Street, New York City 21.

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Problems of Thoracic Surgery will be reviewed at the May 7th meeting of the Hudson County Medical Society which will be held at 9 p. m. at the Masonic Club, 30 Clinton Avenue, Jersey City. Principal speaker will be Dr. Herbert Adams of the Lahey Clinic.

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The American Medical Association has been invited to testify before the Committee on Education and Labor of the U. S. Senate on April 17, 1946, in hearings on the Wagner-Murray-Dingell Bill.

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American College of Chest Physicians will hold its examinations for Fellowship in San Francisco on June 29. Information is obtained from the College at 500 North Dearborn St., Chicago 10.

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Clinical Congress of the American College of Surgeons will be held at the Waldorf Astoria in New York September 9 to 13. For program write to the College at 40 East Erie St., Chicago 11.

• • •

The American Association for the Study of Goiter will hold its annual meeting June 20 to 22 at the Drake Hotel in Chicago. Further details are obtained by writing to Dr. George Shivers, Colorado Springs, Colorado.

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The American Hospital Association will meet in Philadelphia during the week of September 30. Further information may be obtained by writing to the Association at 18 East Division St., Chicago 10.

"Bronchoscopy in Pulmonary Disease" will be the topic of the meeting of the New Jersey Chapter, American College of Chest Physicians, to be held at 1 p. m., May 21 at the Claridge Hotel, Atlantic City. Principal speaker will be Dr. Clerf of Philadelphia.

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Obstetricians and gynecologists are reminded that the oral and tissue examinations for the American Board will be conducted in Chicago, May 6 to May 11. Further details may be obtained from Dr. Paul Titus, 1015 Highland Building, Pittsburgh 6, Pa.

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Otolaryngologists are advised that the University of Illinois is giving an intensive one-week course in that specialty beginning May 13, 1946. Tuition fee is $50. A practical course in bronchoscopy and esophagology will also be given during the week beginning June 3. For further information write to Dr. Francis Lederer, University of Illinois, 1853 West Polk St., Chicago.

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"Hematuria" will be the theme of the May 21 meeting of the Passaic County Medical Society to be held at 9 p. m. on that day in the Freeholders Room of the Administration Building in Paterson. The speaker will be Dr. Ralph C. Yeaw of Paterson.

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An Eastern Association of Electroencephalographers has been formed to promote research and pool scientific information in that field. The president is Lieutenant Commander Robert S. Schwab, U. S. Naval Hospital, Boston, Mass., who will furnish further details to interested physicians.

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Dr. Brooke M. Anspach, Emeritus Professor of Gynecology, at the Jefferson Medical College, delivered the address at the one hundred and twenty-second annual commencement of that College on March 27. His topic was "Life, Liberty and the Pursuit of Happiness." One hundred and five members of the graduating class received commissions in the army, and 29 in the navy. This class brings the total number of graduates of the Jefferson Medical College up to 17,664.

COUNTY SOCIETY REPORTS

ATLANTIC COUNTY

Walter B. Stewart, M.D., Reporter

Regular meeting of the *Medical Society of Atlantic County* was held in new headquarters at the Hotel Ambassador on March 8th, at 9 p. m. Guest speaker, Walter I. Lillie, M.D., Professor of Ophthalmology, Temple University, School of Medicine, Philadelphia, following a dinner in his honor, was introduced to the members of the society by the president, Dr. Guion. Dr. Lillie chose as his subject: *Fundal Changes Associated with Arteriolar Hypertension.* The talk was beautifully illustrated by lantern photos of the fundus in health and in all stages of arteriolar disease, and by slides showing pathologic developments in the fundus. Through the ophthalmoscope one can visualize human pathology in the living state, and by a study of the arteriolar tree can evaluate the clinical status of the patient. The ophthalmologist has often failed to sell to the internist his ability to make a clinical diagnosis from fundal changes alone. He can be the best guide to the obstetrician in advising the proper time for emptying the uterus in eclampsia when hypertensive arteriolar changes are present. Early action in these cases often saves the life of the mother. Dr. Lillie's interesting and valuable presentation was discussed by Drs. Harley, Gordon and Allman.

In the business session which followed, Dr. Allman reported for all three of his committees:

Post-War Committee. A sub-regional office of the Veterans Administration is being opened in Atlantic City. Four full-time positions are open to physicians, whose duties primarily will be examination of veterans for pension purposes.

Legislative Committee. Three bills pending in Trenton should have our united opposition:

1. S 95—by which veterans of World War II, graduates of unapproved medical schools, can be licensed in New Jersey.
2. A 45—same bill, in Assembly.
3. A 47—by which the Department of Health will supplant the State Board of Health, handicapping its administration.

It was moved, seconded and carried that all three measures be opposed and that copies of this resolution be forwarded to our senator and our two assemblymen; and that individual members add their written opposition as well.

Program Committee. The speaker for the April meeting has been chosen from one of our returned medical veterans, Dr. Hilton S. Read. It was voted to invite these veterans to a free dinner as guests of the Society next month.

The application of Dr. Ruben J. Dierwechter for associate membership was referred to the Board of Censors.

BURLINGTON COUNTY

T. Bruce Dickson, M.D., Reporter

Regular meeting of the *Burlington County Medical Society* was held on February 14, 1946, in the Burlington County Hospital, Mount Holly. The president, Dr. Thomas J. Summey, called the meeting to order and welcomed back Dr. Paul R. Sparks of Burlington, who has recently been relieved of active duty with the Army. Dr. Robert E. Haldeman of Mount Holly was at the meeting and is on terminal leave.

Dr. Bernard Leonard of Burlington was elected unanimously to membership in the society.

Guest speaker was Henry B. Decker, M.D., associate professor of dermatology at Jefferson Medical College. His topic was *War Dermatoses Seen in This War.* He stated that war diseases have changed in a life time. In the Spanish war, typhoid fever was the most prominent disease. In World War I respiratory infections were foremost. Since then we have conquered to a large extent both the typhoid fever and the respiratory diseases. In World War II the hardest conditions to combat were the dermatoses seen mostly in the South Pacific area. Although malaria played a prominent part in this war, it was not as disabling as would be expected due to the use of atabrin and quinine. Dr. Decker stated that in the tropics these skin diseases were no different from those in temperate climates except for their severity. In tropical climate, skin diseases run rampant. Such simple things as prickly heat may become greatly accelerated and secondarily infected. Since the soldier is confined to the heat of the tropics it is difficult to heal these lesions. Dr. Decker also said that scabies increases during war in military and civilian life. He stated that the fungus infections such as athlete's foot and the like were treated in the same way as in civilian life. Contact dermatitis seen in the South West Pacific was due to a member of the poison ivy family. The most common drug eruption was due to atabrin which even caused exfoliotiva dermatitis. Dr. Decker's talk was an eye opener to most of us. He showed us that although the dermatoses seen in the South Pacific were much more extensive and formidable looking than we see in the temperate climate, they were, however, the same diseases. It was an interesting talk and much was learned by the members.

With the return of Dr. Anthony V. Ziccardi, Dr. Mendenhall relinquished the job of treasurer to Dr. Ziccardi, who held this position before his entry into the armed services.

Regular monthly meeting of the *Burlington County Medical Society* was held on March 14 at the Burlington County Hospital in Mount Holly. Dr. Thomas J. Summey called the meeting to order and gave a short talk on the facilities for diagnosis and treatment of cancer in this county. He stated that it was extremely important to identify cases as early as possible. Dr. Summey then introduced Mr. J. J. Robinson of Burlington, N. J., chairman of the Cancer Drive in this county . Mr. Robinson told how badly money is needed for this work. According to the figures, he had with him, the county is

supposed to raise twelve thousand dollars. Sixty per cent of this is to stay in Burlington County to be used for patients unable to pay for treatments and medical attention.

Guest speaker of the evening Dr. A. E. Rakoff, Assistant in Endocrinology at Jefferson Medical College, addressed the society on *Recent Advances in Endocrine Therapy.* Dr. Rakoff pointed out that hormones are a double-edged sword; that the wrong hormone might cause damage to the patient. As an example, estrogenic therapy in the treatment of the menopause may over-shadow cancer and may aid in its growth. To determine what hormone is lacking or is present in overabundance, special studies are used. Dr. Rakoff went into detail in describing the menstrual cycle and the hormones involved. He mentioned the more common causes of abnormal menses and stated that dilatation and curettage and daily vaginal smears revealed exactly what the ovary and pituitary glands were doing in the menstural cycle. He pointed out an interesting fact that the female makes two-thirds as much of the male hormone as the male does. The pituitary gland was verbally dissected by Dr. Rakoff and all of its hormones were described. The speaker stressed the fact that these hormones should not be used for more than three months because they will form anti-hormones. Next on his list were estrogenic hormones. He described the commercial products in this category, telling of their efficiency and the strength in which they should be used. Fibroid tumors grow rapidly under estrogenic therapy. Progesterone, according to Dr. Rakoff, is the safest drug to use in amenorrhea but should not be used for more than three days in any one month. He advised giving ten milligrams of progesterone three times a week in the treatment of abortion and to continue this therapy until term. Dr. Rakoff then took up the subject of androgens. In the female, androgens inhibit the pituitary gland and also estrogen formation. He urged a ceiling of three hundred milligrams of testosterone in any one month to a female because masculation may occur. In closing, Dr. Rakoff commented dryly that eunuchs are never bald. This made the bald-headed members of our society feel good.

At the conclusion of the meeting, it was announced that Dr. Edward D. Wildman has now taken over the practice of Dr. Nathan Thorne who practiced for so many years in Moorestown. Dr. Robert E. Haldeman has resumed his practice in Mount Holly and Dr. E. Warren Rodman has returned to Beverly.

CAMDEN COUNTY

Joseph C. Lovett, M.D., Reporter

The *Camden County Medical Society* held its annual Hospital Night meeting at the West Jersey Hospital on March 5th, 1946. The business meeting was presided over by President-elect, Dr. Henry B. Decker. There were seventy members present.

Dr. Vaughn, Dr. Harbeson and Dr. Hughes, newly elected members, were introduced to the Society. Dr. Joseph Newmeyer was elected a member by transfer from the Burlington County Society. Dr. Bentley of the Executive Committee stated that any member whose dues were in arrears for three years should be dropped. Those in arrears one year should be asked to pay their dues. Dr. T. B. Lee of the Committee on Revision of the Constitution stated his work was not quite finished.

Dr. Lee spoke on the American Cancer Society. A determined effort should be made to raise money. Each chapter of that society puts out a project sheet showing what is to be done with the money. Each County Medical Society should support it. Motion was made and passed that the Camden County Society support the American Cancer Society.

The meeting was turned over to Dr. C. F. Hadley who greeted the Society in behalf of the West Jersey Hospital and staff. Dr. Hadley then introduced the speakers of the evening.

Dr. La Favor presented a case of macrocytic anemia treated with folic acid. Charts showing the progress of the patient were projected on the screen. Dr. E. C. Shull showed the x-ray films of the gastro-intestinal tract disclosing marked atrophy.

Dr. Stanley Brown presented a case of ruptured intervertebral disc. Dr. Shull exhibited the films of the spine showing the defect of the disc in the lumbar area. Dr. Brown spoke of how often this occurs and the diagnosis is missed.

Dr. H. Wesley Jack presented a case of ecchinococcic cyst of the liver which he removed. Skin test with the antigen was positive. The pathologic specimen was displayed and Dr. Shull showed the x-ray films of the liver.

Dr. K. L. Athey presented a case of a 76-year-old man with gunshot wound of the brain with complete recovery.

Dr. Samuel Goldman presented a case of ruptured uterus during labor. The baby was in the sac in the abdominal cavity. The patient made a complete recovery.

All papers were excellently presented and enjoyed by all. Following the meeting, refreshments were served.

ESSEX COUNTY

Anthony Ambrose, M.D., Reporter

The *Essex County Medical Society* Council met on February 26. On motion, seconded and passed, it was decided that abstracts of Senate Bill S-95 and Assembly Bill A-45 be sent to veteran members of the Society with return postcards on which disapproval of the bill might be recorded. Dr. Echikson reported that the American Cancer Society is establishing a New Jersey chapter which will cooperate with the work of our Cancer Committee. Dr. Comando reported for the Chronic Disease Hospital Committee that our contacts with Welfare Federation organizations are being maintained. While these agencies favor a chronic disease hospital, the freeholders are reluctant to set up such an institution, although they believe that something should be done, perhaps by expansion of existing facilities.

In connection with the Essex County Society's program for graduate courses, Dr. Crecca delivered the following report:

Educators tell us we are living in a scientific age —at the threshold of the most momentous discoveries in atomic power, chemotherapy, blood substitutes, cancer and tuberculosis control, immunity and longevity in general. Events are moving so rapidly that it is difficult to keep abreast of current advances. There is a lag between new teachings and their acceptance by the profession at large. Confronted with this background, the Post-Graduate Instruction Committee, appointed by your President, set out to evolve a modest beginning toward the goal of approved and accredited graduate training in Essex County.

Guided by an overwhelming response, we inaugurated two separate programs:

1. The Refresher Program for Veterans. This is to provide a comprehensive yet practical review in which recent advances could be incorporated. It was designed to allow veterans to attend at a convenient time, on a part-time basis and free of charge. The enthusiastic response prompted us to enlist the aid of qualified men in the specialty fields in Essex County. Accordingly, the following schedule was put into operation at the Academy of Medicine, 91 Lincoln Park, Newark:

Time: 4:30 to 5:30 p. m. every Monday, Wednesday, Friday
Cardiology—January 25, 30, February 1
Gastro-enterology—February 4, 6, 8, 11
Gynecology—February 13, 15, 18, 20, 22, 25, 27.

This list will be followed on the same days at the same hour by a series of lectures on surgery, pediatrics, internal medicine, orthopedics, otorhinolaryngology, obstetrics, roentgenography, urology, pathology, hematology, neuro-psychiatry and a few other lectures on special topics.

2. The Short Course. The second part of our program, based on the response to the questionnaire, was designed to offer advanced teaching in the desired subjects, financed by tuition fees. As we could not obtain the aid of a graduate school as the sole sponsor, we sought the services of recognized teachers. These courses have received the approval of the Commissioner of Higher Education, thus allowing veterans to be reimbursed for their tuition fees in conformity with Public Law 346. Here is the program:

Course 1A: Cardiology and Electro-Cardiography. Dr. Harry Gold of Cornell University Medical College. Saturdays, 4 p. m. to 5 p. m. Fifteen weekly sessions at the Academy of Medicine, Newark, N. J., beginning January 12, 1946. Tuition $50.00. Registration closed.

Course 2A: Gall Bladder, Liver and Pancreas. Dr. S. S. Lichtman of Mt. Sinai Post-Graduate Department. Fridays, 3:30 to 5 p. m. Eight weekly sessions at the Academy of Medicine, 91 Lincoln Park, Newark, N. J., beginning February 15, 1946. Tuition $50.00. Registration closed.

Course 3A: Surgical Pathology. Dr. M. J. Fein, New York Post-Graduate Medical School. Saturdays, 9:45 to 11:45 a. m. Thirty weekly sessions at Alumni Hall, Seton Hall College, South Orange, N. J. Beginning February 16, 1946. Tuition fee: $150.00. Registration closed.

Course 4A: Gastro-Enterology. Dr. Burrell B. Crohn of Mt. Sinai Post-Graduate Department. Mondays, 4 to 6 p. m. Beginning April 1, 1946, at the Academy of Medicine in Newark, N. J. Tuition fee $75.00. Registration open.

Course 5A: Chest Diseases. Dr. Coleman Rabin of Mt. Sinai Post-Graduate Department. Tuesdays, 4:40 to 6 p. m., at the Academy of Medicine in Newark, N. J. Ten weekly sessions. Beginning April 2, 1946. Tuition fee, $50.00. Registration open.

Our aim, which may take a few years for complete realization and which will necessitate supportive action from the Council, envisages a full academic year of studies in the certified specialties. It embodies a project wherein a school of higher learning will lend its facilities for the expansion of the program in coördination with clinical facilities in the surrounding hospitals so as to meet all the requirements of specialty boards. These factors are necessary for the development of recognized or credited approved graduate work with appropriate residencies which when moulded together will establish a graduate program second to none.

Next year, through the auspices of the Council and under the sponsorship of an academic institution in this area we may be able to launch a full-fledged program of higher education, modeling our plans after the best graduate ideas we can find in conformity with specifications of certifying boards.

At this time, may I express my appreciation for the coöperation of my Post-Graduate Committee.

"A little learning is a dangerous thing,
Drink deep, or taste not, the Pierian spring.
There shallow draughts intoxicate the brain,
And drinking largely sobers us again." (*Pope*)

HUDSON COUNTY

Harry J. Perlberg, M.D., Reporter

Regular meeting of *Hudson County Medical Society* was held March 5 at the Masonic Club in Jersey City. It was called to order by the president, DR. H. H. TYNDALL.

DR. V. P. BUTLER reported receipt of a telephone communication from Dr. J. Lynn Mahaffey, State Director of Health, to the effect that the matter of distribution of dry plasma is still in abeyance but that a definite course of action will probably be determined at a meeting scheduled for March 12.

Announcement was made that a representative of the State Rehabilitation Commission called at the office of the Society in the interest of several young women qualified to accept positions as medical secretaries. Detailed information concerning these applicants may be obtained at the office of the secretary.

DR. J. L. EVANS read the following nominations for 1947:

For *president*, CLAUDIO E. MCNENNEY; for *vice-president*, DAVID I. NALITT; for *secretary*, VINCENT P. BUTLER; for *treasurer*, ANTHONY J. CONTY, and for *reporter*, HARRY J. PERLBERG. For *Board of Trustees*, JOSEPH F. LONDRIGAN, II, and HUGH H. TYNDALL; for *Board of Censors*, A. E. JAFFIN.

For *audit committee*, M. J. WEISS; for *publication committee*, D. I. NALITT, J. J. O'SHEA, S. A. COSGROVE,

W. J. Snyder; for *delegate to State Nominating Committee,* James F. Norton; for *alternate to State Nominating Committee,* J. Lawrence Evans; for *Committee on Constitution and By-Laws,* Miles T. Long; for *Election Committee,* S. G. Scott, L. A. Schneider, James A. McCarren, J. C. Talty, William M. Doody, Samuel S. Schept, J. J. Danielson.

For *Legislative Committee,* V. P. Butler, Frank Marshall, R. S. Driscoll, J. J. Danielson and Edward E. Shapiro; for *Maternal Welfare Committee,* A. A. Mutter, J. H. Jentz, P. A. D'Acierno.

For State Society's House of Delegates: A. P. Hasking, A. E. Jaffin, J. C. Talty, E. A. Cannon, H. J. Perlberg, J. F. Norton, F. J. McLoughlin, J. J Ruvane, W. M. Doody, G. W. Sinnot and Harold Sager.

For *Alternate Delegates:* E. H. Grieco, J. W. McLoughlin, F. R. Arndt, A. S. Goldsmith, L. J. Perkel, V. J. Sheeran, N. L. Shulman, X. T. W. Connelly, S. B. Barishaw, P. A. Simeone, and E. J. Halligan.

After discussion, motion was made and carried to the effect that listing of specialties in the classified section of the telephone directory be henceforth considered contrary to the policy of the Society.

The following applicants were elected to membership: B. P. Abrams of North Bergen; H. L. Aronoff of Jersey City; Sol Aronoff of Hoboken; M. E. Boyland of Jersey City; F. L. Raso of Union City; A. C. Ruoff IIII of Union City; and B. M. Teschner of North Bergen. Dr. P. D. Manno of Bayonne was declared reinstated to membership. Dr. L. T. Bennet of Kearny and Dr. Louis Kominsky of West New York were accepted for membership by transfer, the former from the Rhode Island Medical Society, the latter from the Bergen County Medical Society in New Jersey.

The scientific program opened with a talk on *Deficiency Diseases* by Dr. Norman Jolliffe, Chief of the Nutrition Clinic of New York City's Health Department. The subject was continued by Mrs. Robert Bonthius, Director of Nutrition for the Jersey City Chapter of the American Red Cross. Mrs. Bonthius was introduced by Mrs. Clifford Gould of the American Red Cross. Dr. Tyndall thanked the speakers in the name of the Society for their excellent presentations and expressed appreciation to the Jersey City Chapter of the Red Cross for their efforts and their generous offer of coöperation of trained workers to assist physicians in solving nutritional problems.

PASSAIC COUNTY

J. Reuben Budd, M.D., Reporter

Regular meeting of the *Passaic County Medical Society* was held at the Administration Building, Paterson, on February 19, 1946. In the absence of the president, Dr. Wolfson, vice-president, presided.

Speaker of the evening was Dr. Charles A. Poindexter, Associate Professor of Medicine and Physician-in-Chief to the Cardiac Division of the New York Post-Graduate Medical School. Dr. Poindexter addressed the members on *Rheumatic Fever* and illustrated his paper with lantern slides. The paper was well received and following the address there was much discussion on the subject. Despite the inclemency of the weather, attendance at the meeting was very good.

At the business session, two resolutions were passed, motions being made by Dr. Chester and seconded by Dr. Phelps with the recommendation by the Society that a copy be forwarded to each of the county representatives in the State Legislature:

Be It Resolved, That the Passaic County Medical Society is definitely and totally opposed to Senate Bill 95 which would permit the licensure of graduates of unapproved medical schools.

Be It Also Resolved, That the Passaic County Medical Society is definitely and totally opposed to Assembly Bill 45 which would permit the examination for licensure of a group of graduates of unapproved medical schools who have satisfied the other requirements of the Medical Practice Act.

The following were elected to membership: *Active:* Dr. Thomas Siciliano, Clifton, and Dr. Benjamin M. Krugman, Paterson. *Associate:* Anthony F. Palmeri, Clifton; George E. Legg, Paterson; Harry L. Golish, Paterson; Gustav Friedman, Paterson; Elmer J. Cichon, Clifton; Leonard G. Carusi, Paterson; Louis Salerno, Clifton; Joseph F. Ziagarelli, Paterson; William C. Gordon, Wanaque, and Michael W. Silver, Paterson.

SALEM COUNTY

W. H. Miller, M.D., Reporter

Salem County Medical Society elected the following officers at its meeting on January 18:

William T. Hilliard (Salem), President
Charles L. Savage (Penns Grove), Vice-President
Harry F. Suter (Penns Grove), Sec.-Treas.
William H. Miller (Woodstown), Reporter

Delegates to the State Society:

3 years—Frank L. Perry; Alternate, Wilbur S. Davison
2 years—C. Spencer Davison; Alternate, C. B. Mackes
1 year—Charles L. Fleming; Alternate, M. Chesler

Nominating Delegate: Dr. Frank L. Perry.

UNION COUNTY

Joseph J. Labow, M.D., Reporter

Regular meeting of the *Union County Medical Society* was called to order at 9 p. m. on January 9 at the St. Elizabeth's Hospital, by Dr. Phelan, the President. The session opened with the scientific program, a talk on Rheumatic Heart Disease, by Dr. Jerome G. Kaufman, Instructor at New York Medical College. In the discussion which followed, Dr. W. L. Rumsey stressed the inadequacy of present hospital facilities for the handling of cardiac cases and urged establishment of more cardiac clinics. Dr. Rumsey was recently named pediatrician to the State Crippled Children's Commissions.

Reporting for the Cancer Committee, Dr. Wuester emphasized the need for an educational program and notified the members of the Cancer Information Office in the Court House in Elizabeth. Dr. Stein, Chairman of the Hospital Committee, reported that

no physical improvements are expected in the Elizabeth Isolation Hospital, but that members of the Union County Medical Society were privileged to take care of their own patients there. Fees for non-residents of Elizabeth will be $5 a day. The Committee repeated its recommendation for a county isolation and chronic disease hospital; this report was ordered sent to the Freeholders.

Dr. Blumberg, for the Veteran Physicians Committee, stated that he felt that the program could be handled at the county level without aid from outside agencies. Dr. Blumberg recommended that demobilized doctors who have no hospital connections be granted such privileges, even if only on the courtesy staff. This recommendation was adopted.

The Society went on record as endorsing the work of the National Physicians Committee in its activities in connection with the Wagner-Murray-Dingell Bill and approved active financial support for this Committee by members of the Society.

Announcement was made that the following doctors had applied for membership: Frederick Lerman, J. A. Nevius, Dabney Moon and G. V. C. Zirpolo.

Elected to membership in the Society were Drs. E. J. Landry of Rahway, P. H. Kandra of Plainfield, Max Shapiro of Roselle and S. E. Spivack of Roselle. The new members, all of whom were present, were introduced and signed the Constitution.

A special meeting of the *Union County Medical Society,* attended by physicians, nurses, dentists and pharmacists, was held at the Elk's Club, Elizabeth, January 23, to discuss compulsory health insurance.

Miss Jean Henry, representing the State C. I. O., and Dr. Harold Aaron, representing the Physicians' Forum, spoke in favor of the proposed Wagner-Murray-Dingell Bill. Miss Henry stated that government legislation would bring high standards of medical care to rural areas which lack such facilities. Dr. Aaron said that the main advantage of this bill was that the cost of adequate medical care could be shouldered by compulsory insurance.

Dr. Harrold Murray, President of the New Jersey Section of the American Academy of Pediatrics, discussed the Pepper Bill now in Committee in Congress. He stated that the American Academy of Pediatrics had carefully studied the bill and although favoring its main objectives, definitely is opposed to the measure as now written because it feels that the machinery for its administration leaves much to be desired.

He announced that the Academy will start a national survey of facilities for the care of children and the availability of medical treatment. The facts unearthed by this survey will be placed at the disposal of the government if it wishes to use them to determine the scope of future child health legislation.

Dr. Stanley Nichols, Chairman, Public Health Committee of the State Society, summarized the feeling of the medical profession, emphasizing the need for good quality medical care made available to everyone. Such results can be achieved by creation of a permanent working medical care conference composed of the medical and allied health professions and the governmental agencies concerned with medical service.

Dr. Frederic J. Quigley, past president of the State Society and Executive Secretary of the Legislative Committee of the State Society, emphasized that in the European countries wherever socialized medicine was instituted it was followed by a totalitarian or socialist government.

The general discussion that followed emphasized the feeling that the Wagner-Murray-Dingell and the Pepper Bills will not render the adequate medical care which is claimed by their sponsors. It was also felt that the administrative costs will be excessive.

A special meeting of the *Union County Medical Society* was held at the Alexian Brothers Hospital, Elizabeth, 9 p. m., February 4th, 1946, to discuss the plans for medical care for war veterans.

Dr. Phelan, President, introduced Dr. Norman M. Scott, Director of the Medical Service Administration of New Jersey, who explained that the plan will make it possible for veterans with service-connected disabilities to receive treatment without personal cost from their family physicians.

After a detailed discussion it was moved that the Society coöperate with the Veterans Administration and express its willingness to participate in the evolution of the plan, with the amendment that the Society approve the plan in principle until the end of the fiscal year and in the interim request the State Society to appoint a committee to study the fees with representatives from the different specialists.

It was also moved that a liaison committee be appointed to act between the County Society and the Veterans Administration in order to meet with any problems in regard to adequate care for the medical veterans.

A letter from the *Society of Roselle and Roselle Park Physicians* was read stating that information from reliable authoritative sources has reached the Society to the effect that graduates of unapproved medical schools are applying for licenses to practice in New Jersey and legislation is being offered for enactment in the State Legislature which will allow this to occur. It is strongly felt by the group that this should be immediately investigated. If found to be true the Medical Society of Roselle-Roselle Park wishes to express its opposition and requests that the Union County Medical Society take steps to stop the special legislation that will allow such licensure to occur.

This matter was discussed in great detail as the members felt that such licensing would lower the standards of medical practice in New Jersey. The action of the *Society of Roselle and Roselle Park Physicians* opposing licensing of alumni of substandard medical schools was approved and a motion was passed directing the Secretary to send telegrams to appropriate state and organizational officials indicating the Society's opposition to any lowering of medical practice standards in this state.

WOMAN'S AUXILIARY

PRESIDENT'S MESSAGE

Mrs. William E. Dodd, President

The time is now near at hand for a backward glance over the year's achievements to determine how many of our goals have been reached and to plan to correct our shortcomings in the future. Much good had been accomplished through the efforts of the members of our Auxiliaries and great is the satisfaction in knowing that through your splendid coöperation we have been of assistance to the New Jersey Medical Society in public relations and legislative matters. It is truly said, "In all departments of activity, to have one thing to do, and then to do it, is the secret of success."

Visits have been made to Burlington, Camden, Gloucester and Somerset Counties and to the annual Health Meetings in Hudson and Atlantic Counties. Each phase of safety presented by the Woman's Division of the Newark Safety Council at their first *Home Safety Forum* was most interesting and educational. It is definitely a worth while project to coöperate with the Safety Council.

It has been a great pleasure for me to visit the component County Auxiliaries throughout the State and I take this opportunity of expressing my deep appreciation for the courtesies extended to me. Soon I shall relinquish the honor I have enjoyed as your President, and in behalf of President-Elect, Mrs. Frederick G. Wandall, I ask for the continual loyal support and earnest coöperation given me.

A cordial invitation is hereby given to each doctor's wife in the State to attend the Nineteenth Annual Convention of the Woman's Auxiliary to the New Jersey Medical Society in Atlantic City, May 21st to 23rd. Together we can build a stronger, more effective Auxiliary for "Light is the task where many share the toil."

EXECUTIVE BOARD

MARCH 11, 1946

The Medical Society was characterized as "nothing but the plurality of the family doctors in America" in a talk to the Executive Board of the Woman's Auxiliary to The Medical Society of New Jersey, at the Society's headquarters in Trenton, Monday, March 11, 1946, by Dr. Henry A. Davidson, Editor of the Medical Society's Journal. "The public looks on the individual doctor with esteem and affection," Dr. Davidson pointed out, in a plea that the community be educated to understanding that medical societies were only groups of doctors, entitled to the same understanding and respect that characterized the doctor's individual status. There is, the speaker said, a natural tendency to attribute to organizations a variety of selfish motives which would never be ascribed to individual members of such organizations. The Medical Society's resistance to compulsory sickness insurance is often misinterpreted as an effort on the part of Organized Medicine to protect the economic welfare of the physicians whereas actually, doctors in groups, like doctors as individuals, were motivated chiefly by a desire to maintain health standards. Dr. Davidson suggested that one reason for public misinterpretation of the Society's stand was that too little emphasis had been placed on the affirmative program which Organized Medicine advocated. "It is not a matter of our attacking compulsory insurance and fighting something with nothing; it is rather a matter of our telling the world about voluntary health insurance projects and thus fighting something with something better." Medical Societies, the Editor explained, could easily earn popular good will by simply glamorizing the work of the doctor, but such cheap "honky--tonk" methods were decried as inappropriate to the importance and dignity of the medical profession. The magnificent work of medical societies in advancing scientific knowledge and combatting quackery were further accoladed by the speaker, who pointed out that Organized Medicine's present emphasis on the economics of medical care may have thrown into the shadow these two prior claims on public good will. The speaker called on the Woman's Auxiliary to help advance the health educational programs of the medical society.

The meeting was presided over by Mrs. William E. Dodd of Beach Haven, President. The Program Chairman for the meeting was Mrs. Richard McDonald of Paterson.

FELLOWETTE DINNER

The Annual Dinner of the Fellowettes, the organization of the past-presidents of the Woman's Auxiliary to The Medical Society of New Jersey, will take place Tuesday, May 21, 1946, at 7:30 p. m. in the Mirror Room of The Shelburne Hotel. Mrs. David B. Allman, junior-past-president, is in charge of arrangements.

CONVENTION NEWS

Mrs. James H. Mason, Convention Chairman

The Woman's Auxiliary to The Medical Society of New Jersey will hold its 19th Annual Meeting in Atlantic City, May 21, 22 and 23, 1946. During the past few years, attendance at this meeting has decreased. Now that hostilities have ceased, won't each and every one of you make an effort to be present? Your help is necessary more than ever, if the work of the Auxiliary is to be continued successfully.

Program of the 1946 Convention is as follows:

Tuesday, May 21, 1946

1:00 p. m.—Pre-Convention Board Meeting, Binnacle Room, Claridge Hotel
3:00 p. m.—Rolling Chair Ride

Wednesday, May 22, 1946

9:00 a. m.—Business Session, Belvidere Room, Traymore Hotel
1:00 p. m.—Auxiliary Luncheon ($2.50), Stratosphere Room, Traymore Hotel
3:00 p. m.—Installation of Officers
7:30 p. m.—State Society Banquet, Cambridge Hall, Claridge Hotel ($4.00)

Thursday, May 23, 1946

10:30 a. m.—Post Convention Board Meeting, Binnacle Room, Claridge Hotel

Inasmuch as seating capacity is limited, please send reservations and check for the Auxiliary Luncheon and the Medical Society Banquet to Mrs. James H. Mason, 5501 Atlantic Avenue, Ventnor, N. J.

This is your convention. With the loyal support of all members, we can make this the "best ever". We'll be looking for you in Atlantic City.

AUXILIARY REPORTS

Atlantic County

Mrs. Samuel L. Salasin, Chairman of Publicity

Three talks on pertinent health topics were given on March 8 at a public relations meeting on Public Health Day held by the *Woman's Auxiliary to the Atlantic County Medical Society* in the Hotel Ambassador. Judge Vincent S. Haneman addressed the gathering on Juvenile Delinquency. Mrs. J. Haines Lippincott of Camden discussed Cancer Control and Dr. Elinor Langton spoke on Mental Hygiene.

Mrs. Robert Bradley, chairman of the day's program, opened the meeting by extending a cordial welcome to those present. Mrs. David B. Allman, chairman of the program, presented all speakers. Mrs. William E. Dodd, state president of the Auxiliary, was introduced by Mrs. Bradley and extended greetings to the meeting from the State organization.

Judge Vicennt S. Haneman, the first speaker and Judge of the Atlantic County Juvenile Court, explained the law, pointing out that in this state it is presumed that no one under 16 years of age can commit a crime. "An appearance in the juvenile court does not, therefore, give a child a criminal record. Trial is not by jury, rather the judge is given considerable latitude in each case."

Judge Haneman asserted that he sees no wave of juvenile delinquency in this country. Most cases are merely mischievous and 90 per cent of the time are the fault of the parents. In the State Boys' Home, which is more like a small college than a reform school, the children go to school and learn a trade. The children are never given definite sentences, but are detained for the period deemed necessary. Judge Haneman concluded with the assertion that he is not alarmed at juvenile delinquency in this county and that it is now no more than normal.

In discussing cancer control, Mrs. Lippincott compared the attitude toward cancer today with that toward tuberculosis fifty years ago. People then were reluctant to discuss the subject but once it was brought into the open, constructive measures were taken for its control. Cancer, she said, is no respecter of persons. Contrary to an established belief, children are as susceptible to it as are adults. Cancer, in fact, has killed twice as many children as all other children's diseases combined.

"The death rate of cancer is higher now than ever before and science has said that if it is to continue at the present rate, it can wipe out the human race." Mrs. Lippincott emphatically stated that cancer, if caught early enough, can be cured. A motion picture called *You Are the Switchman* was shown to illustrate Mrs. Lippincott's remarks.

Dr. Elinor Langton, of the Pennsylvania Hospital for Mental Diseases, told the meeting of the necessity for the practice of mental hygiene. "Everybody has a personal responsibility to practice mental hygiene, for few of the potentially mentally ill are under the care of science. Only those who are obviously affected are put under scientific care."

As is the case with cancer, there seems to be a "hush hush" attitude toward mental illness. It can, nevertheless, be prevented. Emotional instability often leads to mental illness. Emotions, however, can be directed into healthy channels by being tolerant, having a sound conscience, accepting responsibility, and having a sense of humor. One's personality should be well integrated mentally, physically and intellectually.

A board meeting conducted by Mrs. Robert Bradley was held before the afternoon's program. At that time plans for a cocktail party to be held at the home of Mrs. Anthony Merendino were drawn up. An executive board meeting of the state society will be held in Trenton on March 11. Henry A. Davidson, the executive secretary of the Public Relations Committee of The Medical Society of New Jersey, will speak on *Public Relations in the Medical Profession.*

Among those present were: Mrs. William O. Roop, Mrs. G. Ruffin Stamps, Mrs. Herman Kline, Mrs. Manuel J. Malley, Mrs. Nan C. Nelson, president of N. J. P. T. A.; Mrs. Elizabeth B. Moore, Dr. Elinor O. Langton (Speaker), Philadelphia, Mental Hygiene subject; Mrs. Samuel L. Kamm, Mrs. Leo Clark, Irena Meseidl, Mrs. Lewis Woolbert, Mrs. H. Largman, Philadelphia; Mrs. Joseph Poland, Mrs. Samuel L. Salasin, chairman of publicity; Mrs. Warren Somers, Red Cross; Mrs. Geneva Brinton, Red Cross; Marge Kissinger, Child Federaton supervisor; Mrs. George H. Wimberg, Mrs. Isabel Hutchinson, Mrs. Frederick Wandall, Mrs. George South, Mrs. Frank Palmisano, Mrs. Anthony Korey, Mrs. Gertrude K. Haidle, Mrs. Alfred Geigerich, Mrs. Edward F. Fitzpatrick, Mrs. Francis S. Friel, Philadelphia; Mrs. Harold J. Byron, Philadelphia; Mrs. V. Earl Johnson, Mrs. Harry Subin, Mrs. J. Carlisle Browne, Mrs. Anthony Merendino, Mrs. Charles Hyman, Mrs. Patrick J. McGohn, Mrs. Robert A. Bradley, Mrs. William E. Dodd, Mrs. A. Haines Lippincott, Elsie M. Casperson, Mrs. Caroline R. Shreve, Judge Vincent S. Haneman, F. M. Haron, L. Aron, Mrs. Frederick Wandall.

Essex County

Mrs. R. S. Marra, Publicity Chairman

The *Woman's Auxiliary to the Essex County Medical Society* held their meeting at the Academy of Medicine on Monday, February 26, 1946, at 1:30 p. m., followed by a Symposium on Nutrition at 2:30 p. m. Guest speakers included Dr. S. William Kalb, chairman of the nutrition committee of the county medical society and a member of the nutrition and obesity clinic of the New York Postgraduate Hospital; Miss Marie Doermann, extension specialist in nutrition of the New Jersey College of Agriculture, and Miss Rita C. Wade, in charge of nutrition, Newark Chapter, American Red Cross.

Miss Doermann spoke on the proper diet for health and the importance of having required amounts of vitamins in order to keep well.

Miss Wade gave an interesting talk on nutrition and its effect on the public in general, including the majority of discharged servicemen.

Dr. Kalb centered his talk around obesity and its effect on nutrition. He told of the way to diet for obesity and still be healthy. In all cases, it is important that a physician be consulted when one wishes to lose weight. Many complications and illness can be the result, when one gets second-hand advice and takes medicine they know nothing about. Under a physician's care and with the proper food diet, an obese person would be able to reduce without doing harm to herself.

Approximately 250 representatives of various organizations were present.

Hudson County

Mrs. Sidney Chayes, Press and Publicity Chairman

The *Woman's Auxiliary to the Hudson County Medical Society* held its Annual Reciprocity Meeting on March 4th at the Young Women's Christian Association, Fairmount Avenue, Jersey City. Mrs. Joseph Murray, Vice-President, received the guests and presided in the absence of the President, Mrs. Edward Murphy.

Mrs. Andrew Ruoff, chairman of Public Relations, presented Dr. Philip Levine, director of the biological division of the Ortho Research Foundation at Linden, N. J., who spoke on the importance of the Rh factor in obstetrics. His talk dealt with hereditary individual differences of human blood and their practical importance in blood transfusions in case of disputed paternity and the newer findings on the Rh factor, particularly in obstetrics.

Dr. Levine indicated how the lives of many mothers can be saved by the proper selection of bloods for transfusion the Rh negative mothers and also the Rh infants who may be victims of the Rh incompatibility.

Two high school students, the winners of the essays on "Advances in Medicine Resulting from the War", were introduced to the group and read their papers. Mrs. Ruoff presented Miss Helen Kelly and Thomas Timlen with a War Bond. Following the meeting tea was served with Mrs. Oscar Jacks and Mrs. Ellis Chapman pouring.

Mercer County

Mrs. C. Chester Chianese, Publicity Chairman

The *Woman's Auxiliary to the Mercer County Medical Society* will sponsor a Dinner-Dance in conjunction with the Medical Society, at the Trenton Country Club, on Wednesday, May 8th, 1946, at 8 p. m.

Mrs. John F. Kustrup, chairman of the affair, held a meeting at her home on Friday evening, March 15th, to further plans. The committee assisting Mrs. Kustrup are as follows: Mrs. H. Donald Cowlbeck, President of the Auxiliary; Mrs. C. Chester Chianese, Mrs. Robert J. Cottone, Mrs. Joseph R. Burns, Mrs. William C. Ivins, Mrs. Ernest F. Purcell, Mrs. Paul Klempner, Mrs. Charles C. Cohan. Mrs. Paul J. Finegan, Mrs. James J. McGuire, Mrs. J. F. Johnson, Mrs. Joseph S. Kondor, Mrs. Ralph J. Belford, Mrs. Patrick H. Corrigan, Mrs. William P. McCarthy, Mrs. Harold Magee.

Dr. William E. Mountford is Entertainment Chairman of the Mercer County Medical Society. Committee assisting Dr. Mountford are as follows: Dr. George A. Corio, Dr. Donald C. Lynch, Dr. James A. Fessler, Dr. Josepf S. Vanneman. Dr. Richard T. Buckley of Hightstown is President of the Mercer County Medical Society of New Jersey.

BOOK REVIEWS

Atlas of Surgical Approaches to Bones and Joints. By Toufick Nicola, M.D., F.A.C.S. Pp. 218, illustrated. New York, The Macmillan Company. 1945. $5.00.

Here are 218 pages of beautiful drawings illustrating surgical approaches to the bones and joints, showing the skin incision and the important structures encountered by the surgeon in exposing the tissue to be operated upon. The book starts with the shoulder girdle and takes in the upper extremity, the trunk including the neck, the lower extremity, and the skull. All common approaches and skin incisions are shown including the recently published posterior approach to the femoral shaft. Illustrations are by the author and each plate is a work of art. The structures are clearly designated and text, while reduced to a minimum, includes the essentials.

The book fills the long felt need of most orthopedic and traumatic surgeons who like to brush up on the anatomy involved before doing an operation. Up to now the surgeon has had to go to the anatomy books and review the muscles, blood vessels, and nerves separately and then try to synthesize them into a picture to hold for the approach that he intended to make on the following morning. This has always been difficult. With this excellent book, all he has to do is to look at a few clear illustrations and everything he needs to know is pictured before him.

This book will be enthusiastically received by the surgically inclined medical men from interns to professors. It is a volume that will not become outmoded. Your son and grandson will find it just as useful as you do.

Orchids to Toufick Nicola!

Harry Briggs, M.D.

Suggestion and Hypnosis Made Practical. By Samuel Kahn, M.D. Pp. 200. Boston. Meador Publishing Co. 1945. $3.00.

Not intended for doctors at all, this is a layman's book on how to win friends and influence people. In spite of its title, it does not tell the physician how to perform hypnotism in his practice. The scientific soundness of some of Kahn's statements is open to question. For instance, he writes that "suggestion has been used to induce the commission of crime". The book is written in the popular style characteristic of so many self-help texts. It abounds in anecdotes of how teacher got Johnny to practice his piano lessons by the use of "positive" suggestion, and how mother (not familiar with Kahn's book) did damage to her little Mary by barraging her with "negative" suggestion. Everyday examples from the fields of business, law, religion, medicine and advertising maintain reader interest. Whether a neurotic would be helped by reading the volume is doubtful; no physician will want to prescribe it without first examining the book for himself. Apart from this, about the only value the text might have for doctors would be as a source-book for ideas when he is called on to give a popular talk on some aspect of applied psychology.

Henry A. Davidson, M.D.

Psychology of Women: A Psychological Interpretation. By Helene Deutsch, M.D. v. 2, Motherhood. By Helene Deutsch, M.D. Pp. 498. New York, Grune & Stratton. 1945. $4.50.

Once it was thought that a woman's place was in the home. Today there is hardly a field of endeavor outside the home in which she has not found a place.

In this volume, Dr. Deutsch continues the study of the *Psychology of Women* begun in her first volume and carrying on from marriage through motherhood to that period when with the cessation of reproductive functions, woman ends her rôle as a servant of the species.

In connection with the employment of anesthesia in childbirth, Dr. Deutsch suggests that use of anesthetics may produce unfavorable psychologic reactions. By depriving the woman of the feeling of accomplishment in mastering fear and pain, the mother-child relationship is disturbed and a barrier of separation set up which may have far reaching results in that the emotional estrangement which ensues may persist for a long time.

In her discussion of unmarried mothers Dr. Deutsch calls attention to the fact that the problem of illegitimate motherhood in communities where it is not stigmatized is very different from what it is in communities where illegitimate motherhood results in the woman being ostracized.

Since the study deals with the reproductive years of a woman's life it concludes with a discussion of the climacterium. How a woman reacts to this period will depend not only on her personality but on the psychologic experiences which have preceded it through the years. Many women, highly gifted intellectually and artistically, are capable of making valuable contributions in their chosen field and many may find their compensation in the joys of grandmotherhood. However, many unmarried and childless women, because of economic necessity, have had to renounce motherhood in which they would have rejoiced. For all these women, particularly for those with few if any family ties, advancing age is a specter which haunts most of their waking hours. Old memories and fears find their way once more into their conscious minds in addition to new fears and often a tremendous feeling of insecurity.

The thought that is uppermost throughout the book is that in motherhood woman finds her deepest satisfaction. Biologic motherhood, however, is not enough. Coupled with it must be that personality trait, motherliness, which Dr. Deutsch defines as being made up of psychologic phenomena related to the child's helplessness and need for care. For a woman thus happily well adjusted, motherhood holds a rich reward giving her as it must the feeling of having a share in the eternal life stream.

It is an interesting book, provocative, affording food for thought, and well worth reading.

Grace W. Sims, Senior Case Worker,
Essex County Welfare Board.

Principles of Dynamic Psychiatry. By Jules H. Masserman, M.D. Pp. 322. Philadelphia & London, W. B. Sounders Company. 1946. $4.00.

The Principles of Dynamic Psychiatry will appeal to two groups of readers: (1) those not overwhelmingly committed to some other school of psychiatry, and (2) those who, though instinctively hostile to psychoanalysis as a total concept, grudgingly acknowledge that it has something to offer. Dr. Masserman's training under Adolf Meyer and Franz Alexander indicate that psychobiology and psychoanalysis would contribute to the formulation of biodynamics, and an examination of the book confirms that impression. Biodynamics may be conceived as psychoanalysis approached from a psychobiologic point of view and integrated with the work of Pavlov and Watson. In the total reintegration of the contributions of these different schools purely dogmatic, doubtful and obsolescent concepts are discarded, leaving a healthy base for further development.

Biodynamics is not restricted to human beings but is applied to the behavior of all living organisms. It views organismal behavior as directed toward the satisfaction of physiologic needs, and modified by the organisms' capacities and experiences.

The biodynamic formulation is thus a reinterpretation of the more esoteric concepts of the other psychologies and gives them the biologic base that Freud considered necessary. In integrating biology with psychiatry, biodynamics becomes the first school of psychiatry to combine clinical observation and analysis of human behavior with experimental data on the production of neuroses in animals.

The book is valuable not only for its introduction of a new dynamic interpretation but also for a critical exposition and evaluation of the other psychologies. In addition there is an informative chapter on mass psychology. The author's style is sometimes sketchy, sometimes pedantic, but this is to be expected in a bare presentation of first principles.

Morton M. Stern, M.D.

Group Psychotherapy. By J. W. Klapman, M.D. Pp. 320. New York, Grune and Stratton, 1946. $4.00.

In this brave new world where houses are prefabricated in bulk, furniture comes off a belt line and men and women are college-educated in huge groups, the doctor can hardly expect to retain treatment on a tailor-made individualized basis. Fifty thousand of us in the Army and Navy learned how it was possible to examine and treat patients on a production-line basis. How the rising tide of health insurance will modify the previously individualized basis of the doctor-patient relationship remains to be seen. To general practitioners it appears as if the psychiatrist alone remains as a solitary bastion of individualized handling. But not for long. Psychiatric treatment *en masse* is here to stay, and Klapman's book, the first text to describe group psychotherapy for adults, will not be the last.

After a 45-page diversion into the historical, cultural and anthropologic roots of group therapy, the author plunges into his subject with a review of the theoretical dynamics of the process. Bulk of the volume, however, is devoted to a report (not a manual) of the methods of administering group therapy with mention of psychodrama, group hobbies, patient-clubs, institutional publications and the operation of outpatient therapeutic group. The book is not precisely a *vade mecum* for group leaders. At least Klapman does not describe in 1-2-3 fashion just how you organize a group, seat the participants, allow for time, start the discussion or keep it going. But it does provide the therapist with a rich reservoir of background material with numerous well documented illustrative case reports. The style is a bit uneven. In spots the author becomes enmeshed in his own jargon (example: "Orientative desiderata, which are a step from the immediate concerns of the narcissistically constituted person") while in other parts of the book, the text is clear and readable: An extensive bibliography adds immeasurably to the usefulness of the volume.

Henry A. Davidson, M.D.

BOOKS RECEIVED FOR REVIEW

Howell's Textbook of Physiology. Edited by John F. Fulton, M.D. 15th ed. Pp. 1304 with 507 illustrations. Philadelphia & London, W. B. Saunders Company. 1946. $8.00.

Gastro-Enterology. By Henry L. Bockus, M.D. Vol. 3—The Liver, Biliary Tract and Pancreas, and Secondary Gastro-Intestinal Disorders. Pp. 1091 with 427 illustrations, some in colors. Philadelphia & London, W. B. Saunders Company. 1946. 3v & separate desk index, $35.00.

Nursing in Commerce and Industry. By Bethel J. McGrath, R.N., for the National Organization for Public Health Nursing. Pp. 356. New York, Commonwealth Fund. 1946. $3.00.

Medicine in Industry. By Bernhard J. Stern, Ph.D. Pp. 209. New York, Commonwealth Fund. 1946. $1.50.

Nursing and Nursing Education. By Agnes Gelinas, R.N., A.M. Pp. 72. New York, The Commonwealth Fund. 1946. $1.00.

Tuberculosis Abstracts

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XIX **April, 1946** **No. 4**

THE general practitioner of medicine armed with newer methods of diagnosis and aware of the limitations of earlier diagnostic procedures can recognize tuberculosis in its early stages if he has a lurking suspicion it may be present. Such a suspicion will arise more often when recent developments in the diagnosis of chest diseases are reviewed.

THE EARLY DIAGNOSIS OF DISEASES OF THE CHEST

The early diagnosis of diseases of the chest is more important today than at any time in the history of medicine. Mass X-ray surveys have revealed that intrathoracic abnormalities and diseases are more frequent than has hitherto been suspected. Modern diagnostic procedures make early diagnosis more easily attainable than before. Modern medical and surgical procedures have increased the chances of control or cure in most diseases of the chest.

Not so long ago the physician had to rely on the history, the physical examination and inadequate bacteriologic study of the sputum to establish a diagnosis of intrathoracic disease. Diagnoses could be made during this era only when the pathologic process was in an advanced stage. In recent years, however, fluoroscopy and roentgenography have become universally available. Bronchoscopy has been perfected so that it can now be performed with only slight discomfort to the patient and with little risk. Better bacteriologic technics have been developed. Aspiration biopsy of lung tumors is helpful in certain cases. The advance in medical and surgical therapy of chest lesions has kept pace with the diagnostic developments.

In spite of these facts, 60 per cent of tuberculous patients who are referred to sanatoriums have far advanced disease, and only 10 per cent have minimal lesions. Less than 25 per cent of the patients with cancer of the lung are referred for surgery before extension of the tumor has occurred. Recently Overholt discovered that among 153 patients with cancer of the lung an incorrect diagnosis had been made in 95 cases (60 per cent). Treatment based on this had been maintained for long periods of time.

There may be several reasons for the delay in diagnosis. The patient frequently delays going to the physician because he has few or no symptoms; the presenting clinical picture often suggests another diagnosis; physical examination is notoriously unreliable; and the application of rigid diagnostic methods is often delayed because the physician has not developed a sufficiently strong suspicion of the underlying disease.

No attempt will be made to cover completely the symptoms associated with intrathoracic diseases, but the following points require emphasis. Almost all the diseases of the chest have an early asymptomatic stage, during which the pathologic process can be discovered only by x-raying the chest. This stage is apt to be so mild that the seriousness of the underlying lesion is overlooked. Cancer and tuberculosis may masquerade as each other, or as any of the commonplace diseases of the chest, or as an entirely foreign clinical picture, such as arthritis.

Physical examination of the chest is essential in the evaluation of any patient, but the time has come to recognize its limitations as well as its value. As early as 1933, Sampson and Brown reported that moderately coarse rales at an apex were the only reliable data obtained on physical examination, and added that these were present in only 27 per cent of the minimal cases. They analyzed the occurrence of the five cardinal signs and symptoms of tuberculosis in a series of 280 cases with minimal disease. Tubercle bacilli were found in the sputum in 35 per cent, rales in 27 per cent, hemoptysis in 26 per cent, pleural effusion in 12 per cent, and x-ray evidence of pulmonary tuberculosis in over 99 per cent. In car-

cinoma of the lung, physical signs are extremely unreliable and at best only suggestive.

Roentgenologic study of the chest should be a routine procedure in the examination of every patient admitted to hospitals and institutions. In the light of present knowledge, routine roentgenologic study of the chest is at least four times as important as blood cell counts, urinalyses or other routine procedures now in use. It also serves to protect patients and hospital personnel against the unsuspected active cases of tuberculosis that are constantly present in hospitals. Fluoroscopy or photofluorography require little time and can be done at a cost of only a few cents a patient.

In every patient suspected of having tuberculosis careful sputum studies should be performed in an attempt to confirm the diagnosis. To avoid delay, the use of routine smears should be avoided. These smears are so unreliable that a negative result is meaningless. Three consecutive seventy-two hour pooled sputum specimens should be concentrated. If they are negative on microscopic examination, the sediment should be cultured and inoculated into guinea pigs, and three consecutive gastric lavages examined immediately by the concentration method. Acid-fast bacilli found in gastric lavages when the sputum is negative should always be cultured and inoculated into a guinea pig to identify the acid-fast bacilli as tubercle bacilli. When these tests are repeatedly negative in a patient with a demonstrable parenchymal infiltration in the lung that is apparently active, the lesion is probably non-tuberculous, and other diagnostic procedures are indicated.

Any patient with a visible tumor or an unexplained density or suppuration in the lung, especially if he is in the middle or older age group, should be suspected of having a pulmonary cancer. Such patients should be bronchoscoped immediately; 60 to 70 per cent of bronchiogenic carcinomas originate in the major bronchi, and a biopsy specimen to establish the diagnosis can be obtained.

Surgical exploration of the chest is a safe procedure, and should be utilized more frequently to determine the etiology of unexplained pulmonary lesions. Aspiration biopsy is used to secure tissue for pathologic study only in cases that are obviously inoperable. In patients in whom operation is possible, exploration is safer and more accurate.

The responsibility for the early apprehension of pulmonary disease rests largely on the shoulders of the general practitioner and the internist, since they are the first to see the patient. Their offices should and can be the greatest case-finding agencies in the entire field of medical practice. To make this possible, the limitations of the history, the physical examination and certain laboratory procedures must be more keenly appreciated, and rigid diagnostic procedures must be applied routinely.

The Early Diagnosis of Diseases of the Chest, Norman J. Wilson, M.D., New England Jour. of Med., March 15, 1945.

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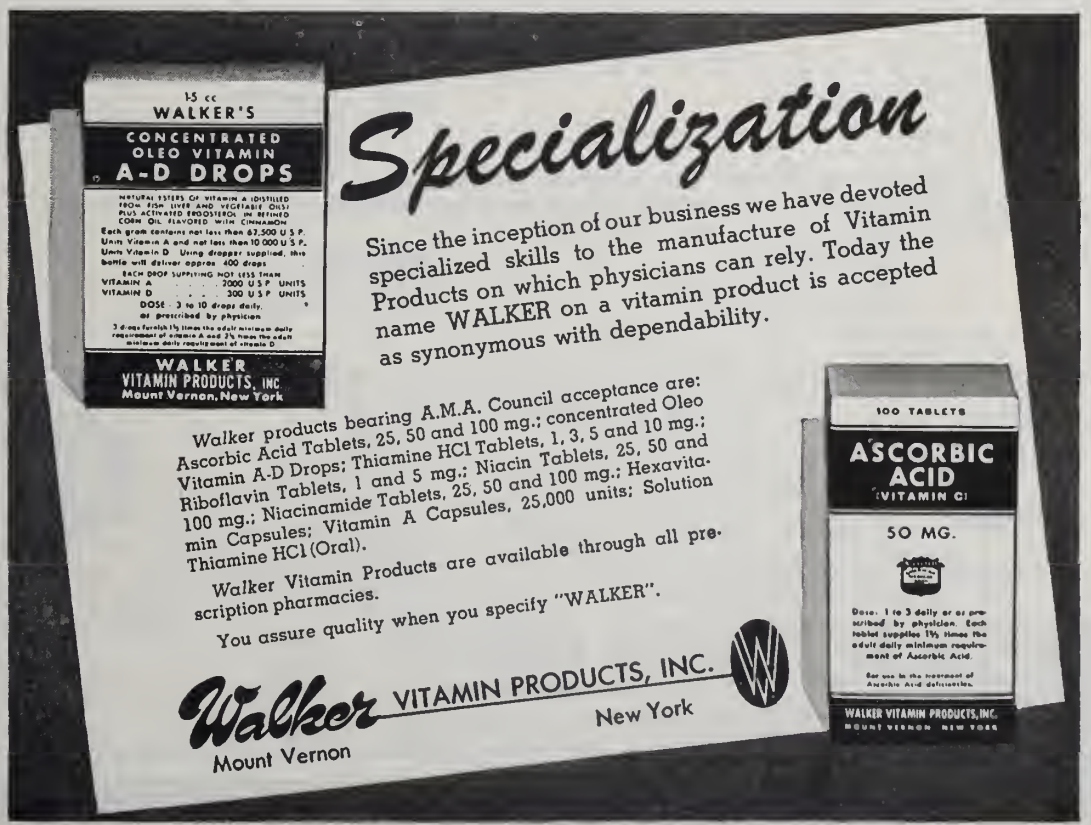


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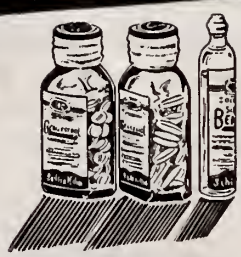
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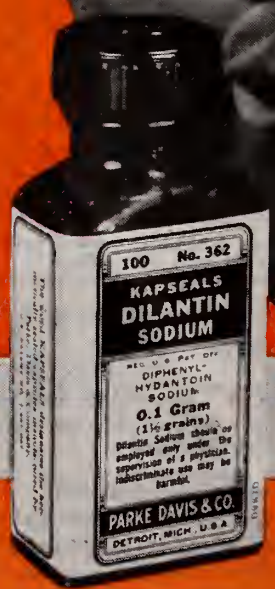
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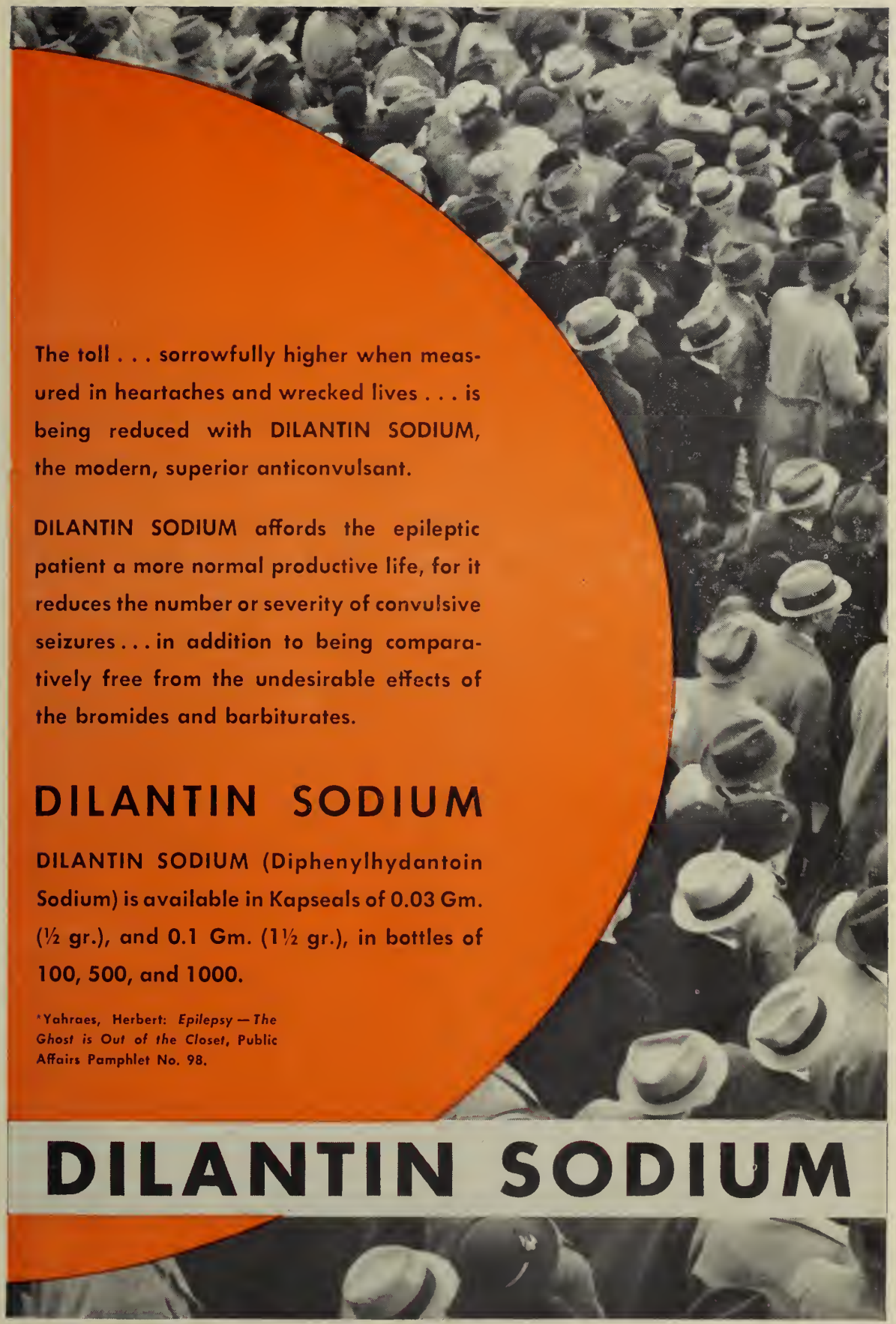
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*Yahraes, Herbert: *Epilepsy — The Ghost is Out of the Closet*, Public Affairs Pamphlet No. 98.

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OF

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Entered as second-class matter, September 5, 1906, at the post office at Orange, New Jersey, under Act of March 3, 1879.

VOL. 43, NO. 5 MAY, 1946 Subscriptions, $3.00 per Year
Single Copies, 30 Cents

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Roster of Officers and Committees, Advertising Pages 3A-7A

Place of Publication, Printing and Mailing:
12 South Day St., Orange, N. J.

Editorial and Executive Offices of the Society:
315 West State St., Trenton 8, N. J.

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BErgen 4-6051

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766

PLACE OF PUBLICATION, PRINTING AND MAILING, 12 SO. DAY ST., ORANGE, N. J.
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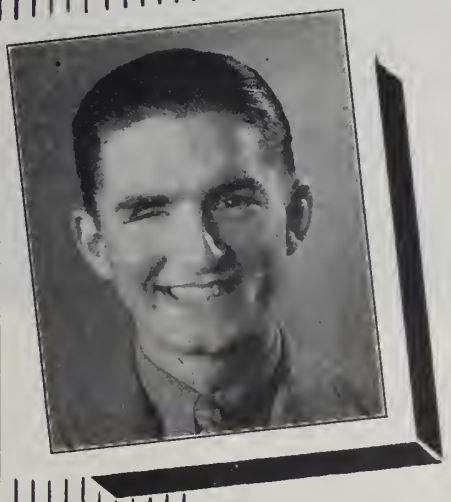
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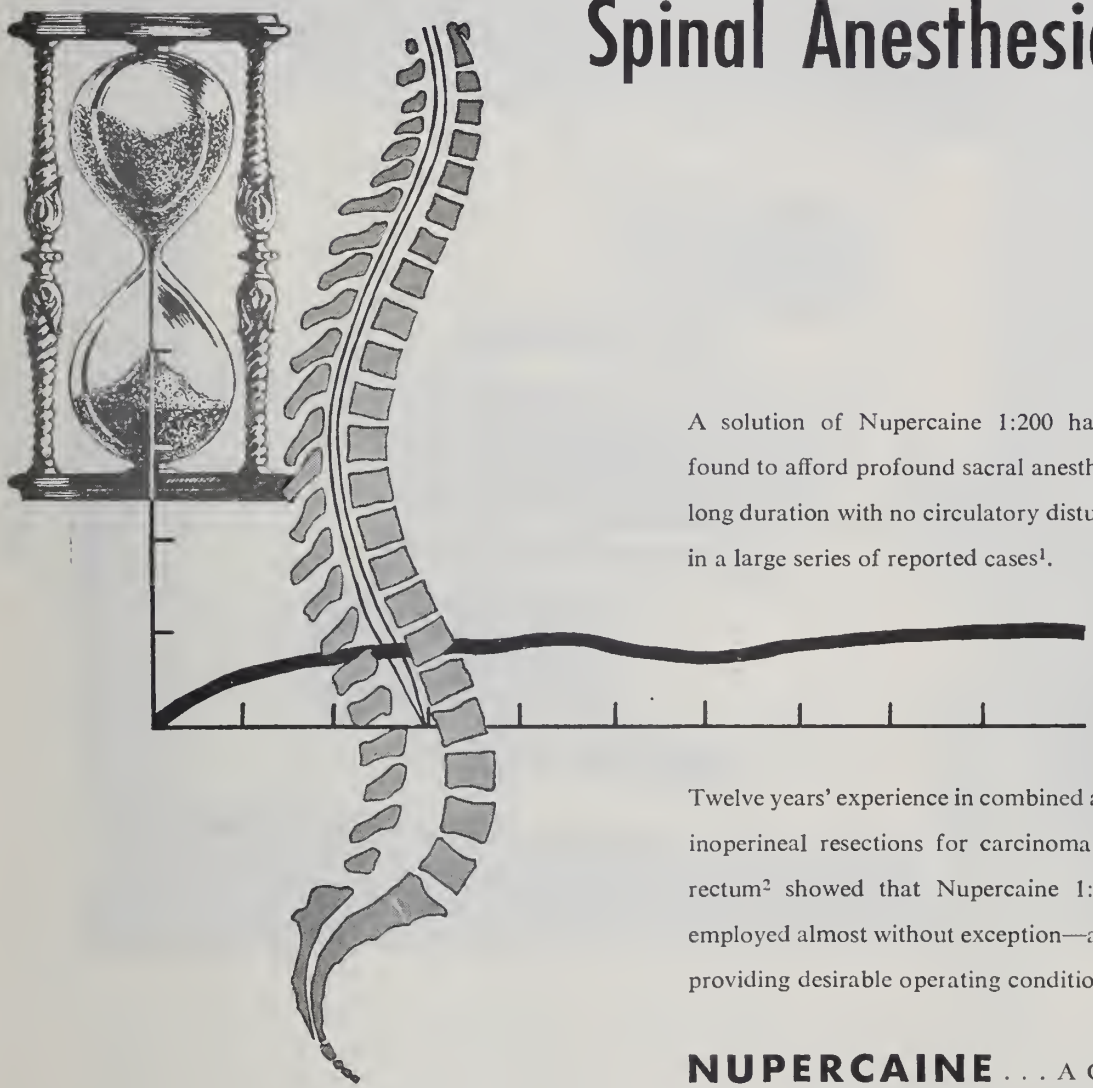
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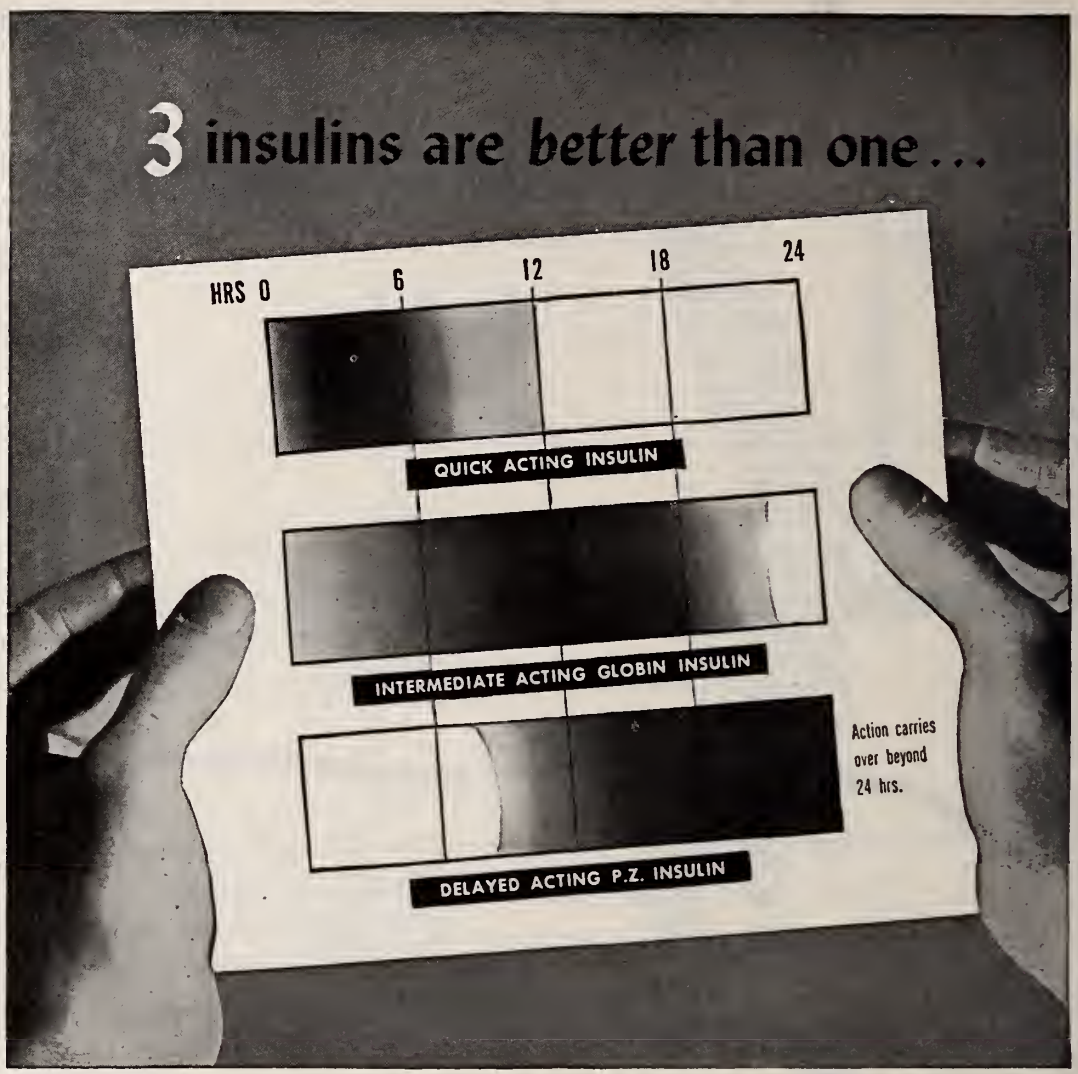
1 Clement, F. W. & Elder, C. K.: Anesth. 4:516, 1943
2 Coller, F. A. & Ransom, H. K.: Surg. Gynec. & Obst., 78:304, 1944

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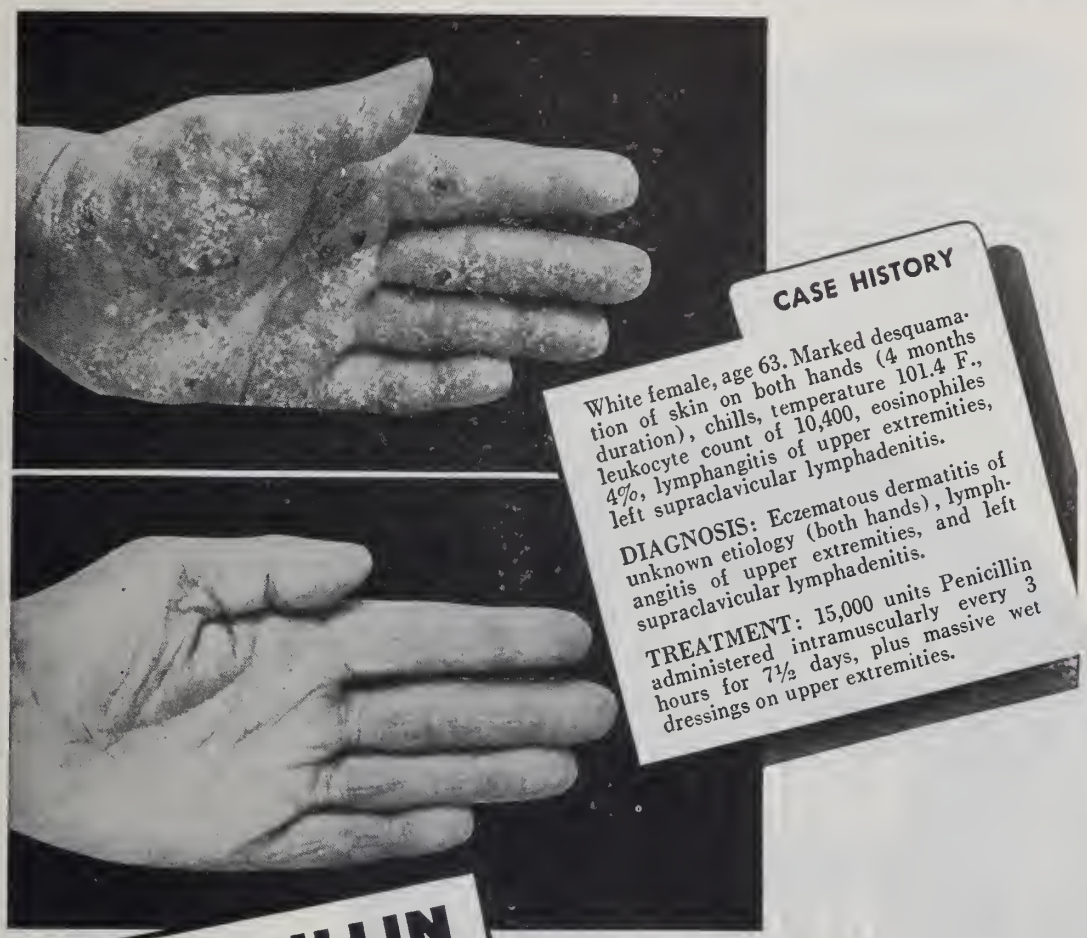


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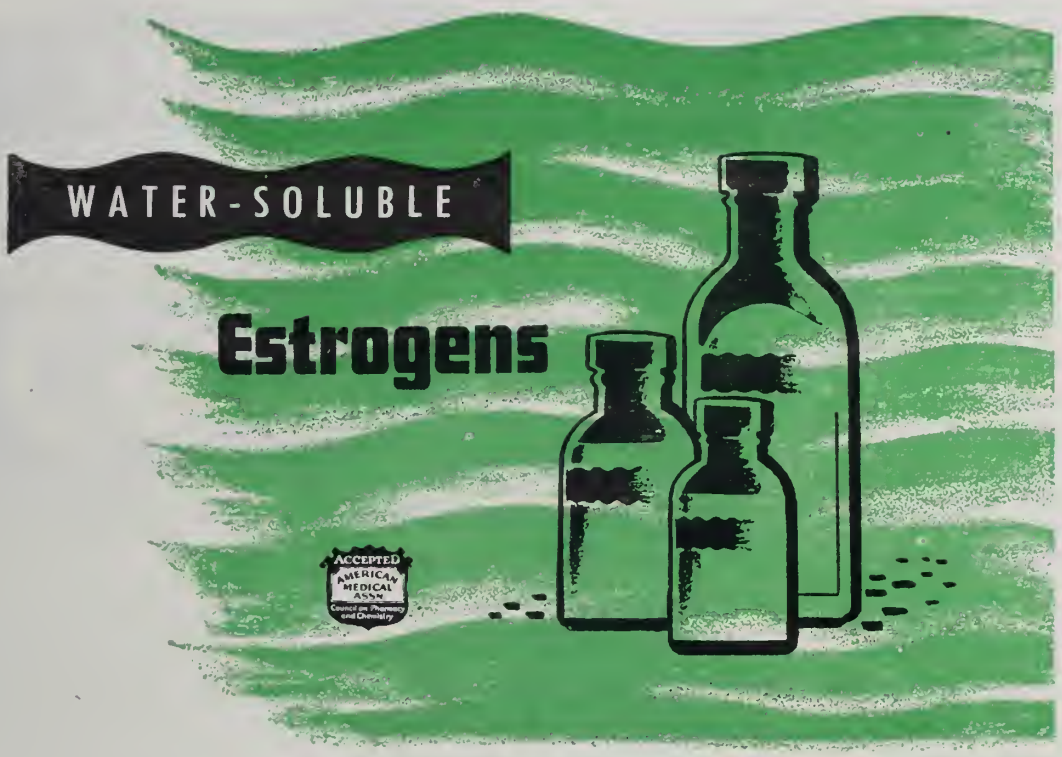
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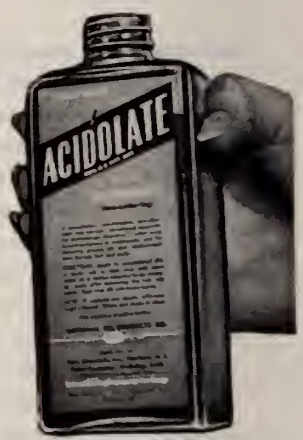
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REFERENCES—(1) Boyer, N. H.: J.A.M.A. 122:307, 1943. (2) Clement, S. C.: Med. Rec. & Ann. 38: 755, 1944. (3) Gilbert, N. C.: Quart. Bull. Northwestern Univ. Med. School 16:179, 1942. (4) Gilbert, N. C. & Kerr, J. A.: J.A.M.A. 92:201, 1929. (5) Stroud, W. D.: Diagnosis & Treatment of Cardio-vaseular Disease, Vol. 1, Chap. 22. (6) White, P. J., Bland, E. F. & Miskall, E. W.: J.A.M.A. 123:801, 1943. (7) Wippern, V. & Gunn, S. A.: Med. Times 70:197, 1942. (8) Ziskin, T.: Jnl.-Lancet 58:292, 1937.

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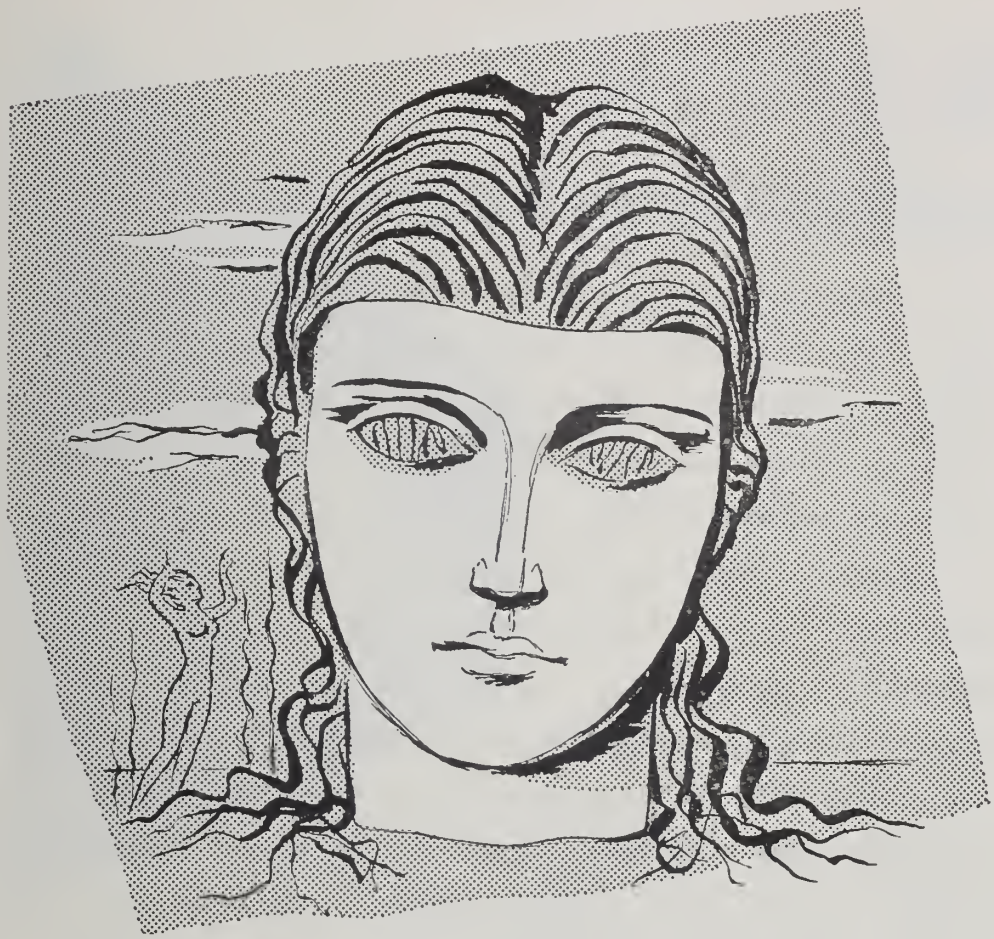
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The fundamental concept, that nutritional requirements must be met in disease as well as in health, holds especially true in renal disease.[1] Because many affections of the kidney involve excretion of blood albumin via the urine, the intake of protein in former years was curtailed in a futile attempt to stem the loss of protein.

Modern nutritional science has emphasized the necessity for maintaining nitrogen balance even in the face of the severe albuminuria characteristic of lipid nephrosis.[2] Not only must the basic nitrogen requirements of the organism be met, but the urinary loss must be compensated for as well.[3] Only when this adjustment of protein intake is made can the plasma albumin be restored to normal levels and the associated edema overcome.

Meat is an excellent source of protein in the management of nephritis and nephrosis, not only because of the high percentage of protein contained, but especially because its protein is of highest biologic quality, applicable for every protein need.

---

1 *Stare, F. J., and Thorn, G. W.: Protein Nutrition in Problems of Medical Interest, J.A.M.A. 127:1120 (April 28) 1945.*

2 *Stare, F. J., and Davidson, C. S.: Protein: Its Role in Human Nutrition; Introduction, J.A.M.A. 127:985 (April 14) 1945.*

3 *Anderson, G. K.: The Importance of Protein in Diet Therapy, J.Am.Dietet.A. 21:436 (July-August) 1945.*

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

ACCEPTED AMERICAN MEDICAL ASSN Council on Foods and Nutrition

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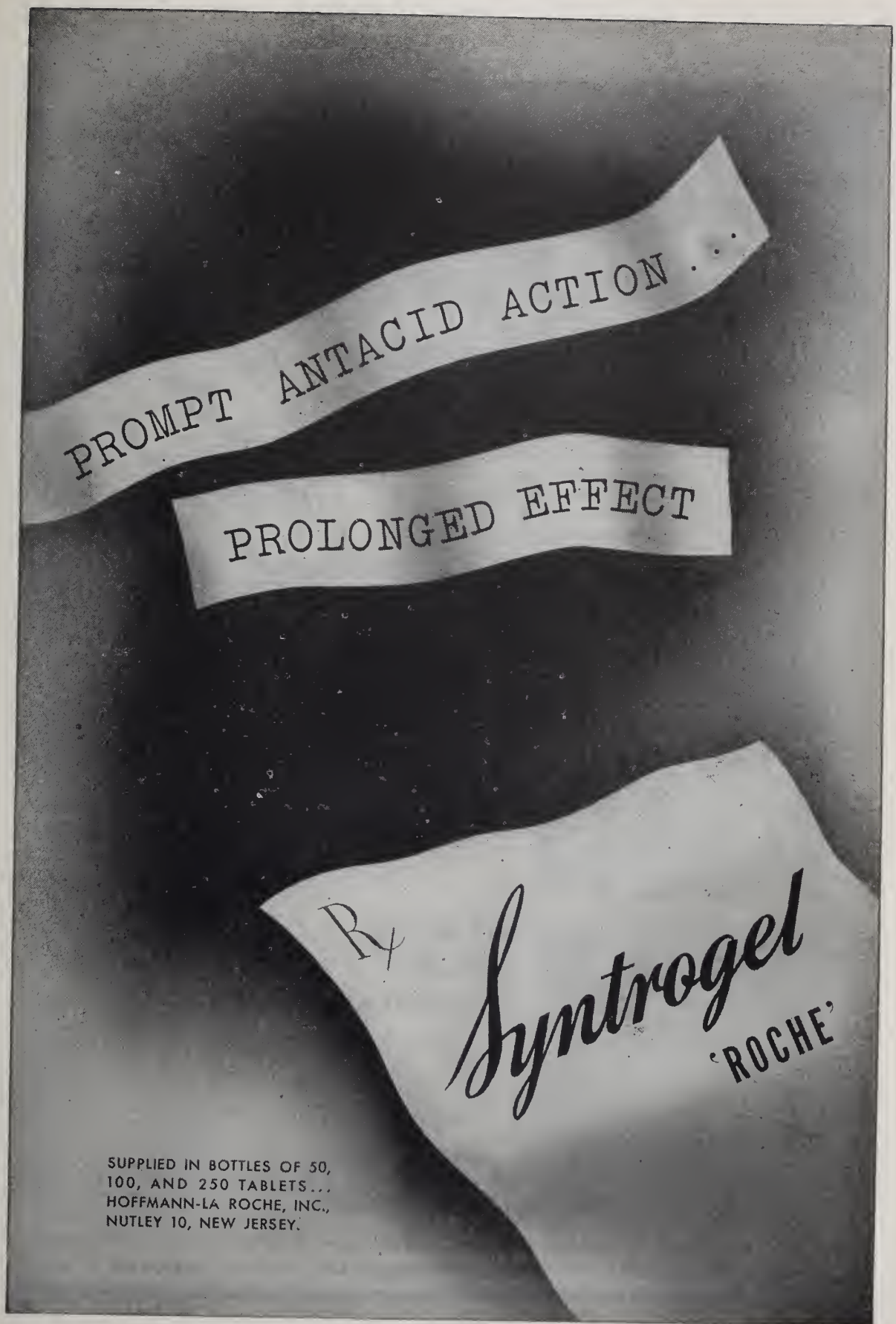
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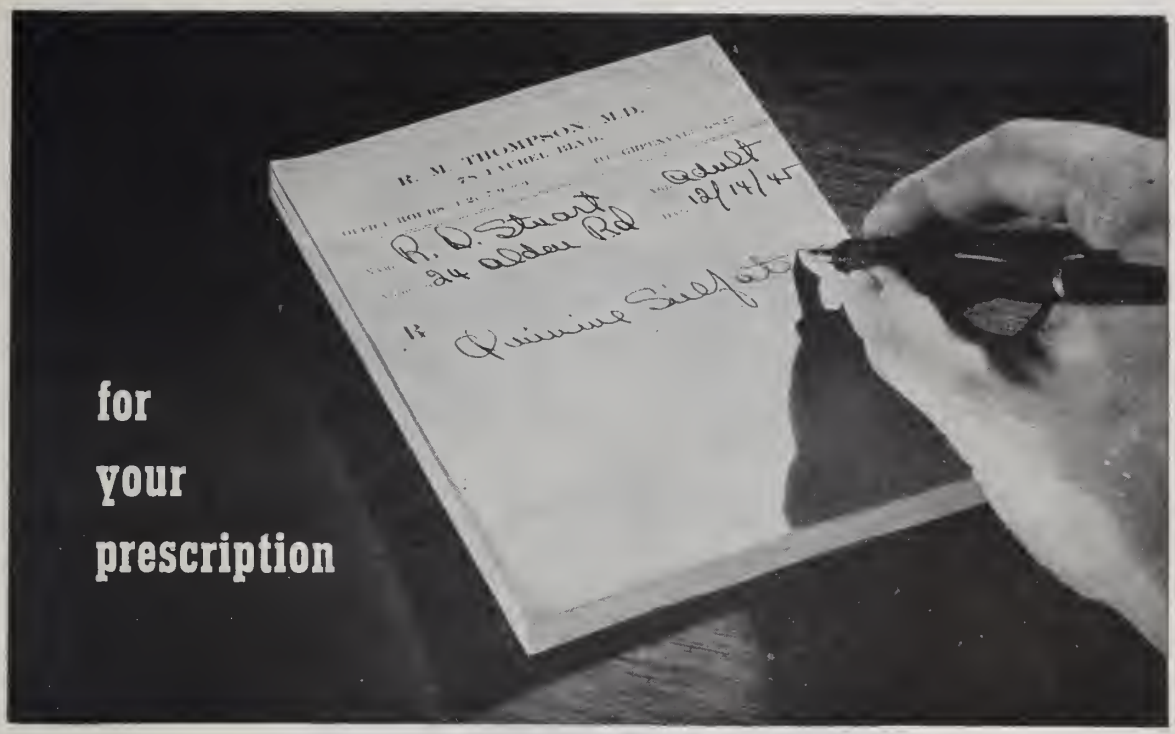
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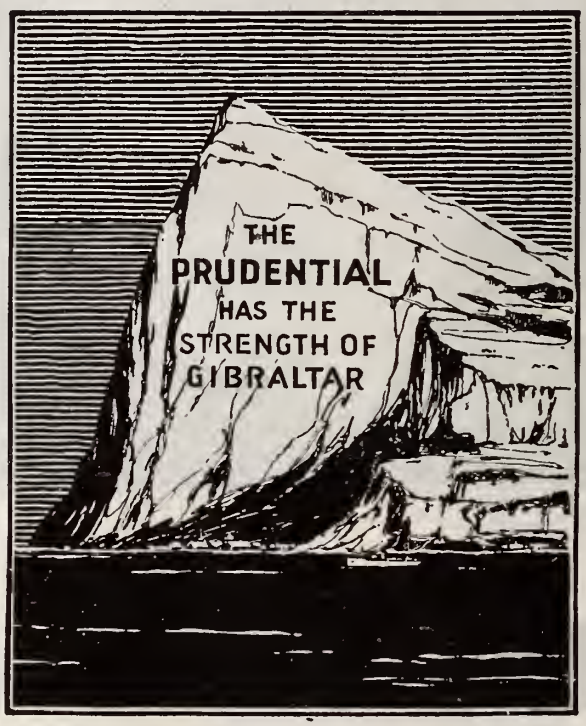
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WALKER-GORDON

Acidophilus

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Patient of intermediate type-of-build (skeleton indrawn)

This lumbosacral support is specifically designed to limit the range of the lumbar spine bending when either the framework or soft tissues of the low back are the seat of injury or disease. Effective support is given the gluteal region, the lumbar spine and the sacro-iliac and lumbo-sacral joints. The adjustment about the pelvic girdle prevents undue pressure of the upper adjustments and yet the presence of the center adjustment gives relief and comfort to the patient. Provision is made for reinforcement with aluminum uprights when indicated.

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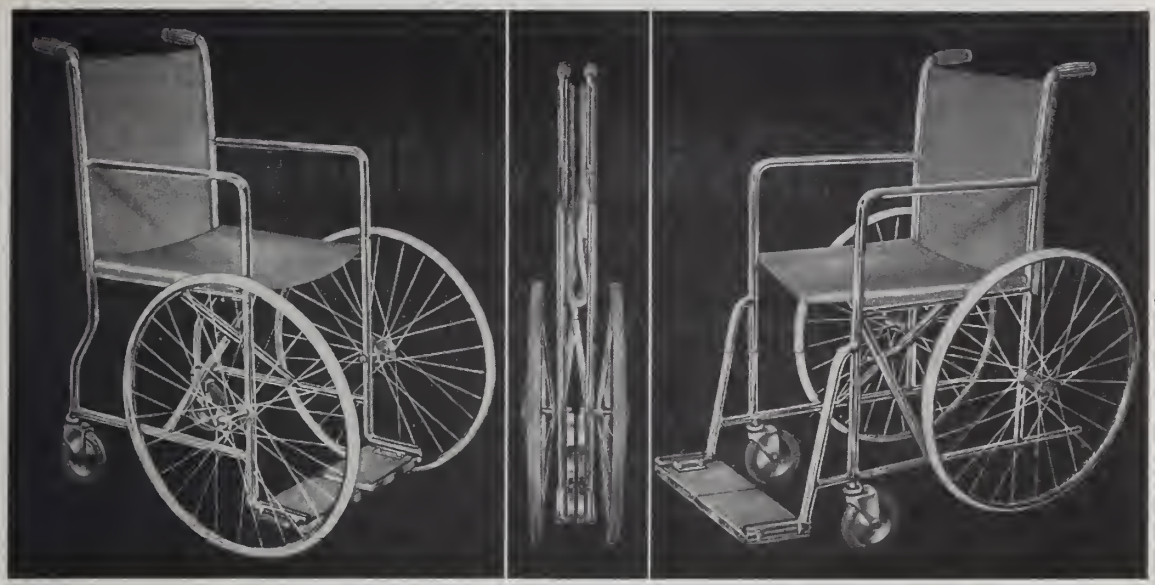
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1. Virginia M. Monthly 72:240 (June) 1945.

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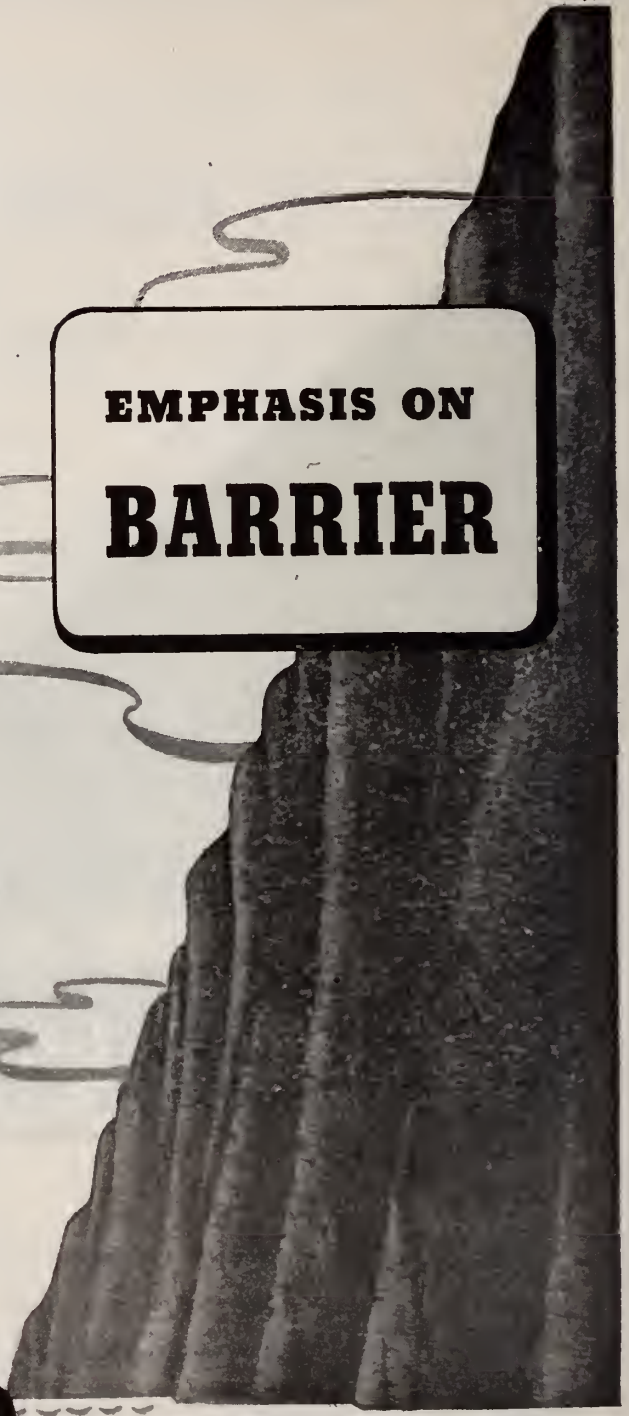
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1. Clinic Reports: Planned Parenthood Services in the United States. Human Fertility 10: 25 (Mar.) 1945.
2. Dickinson, R.L.: Techniques of Conception Control. Baltimore, Williams and Wilkins Co., 1942.
3. Warner, M.P.: J.A.M.A. 115: 279 (July 27) 1940.



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SCRUBBING the operative field with soap and water effectively eliminates most of the bacteria. But before the surgeon makes his incision, he must be certain that the last troublesome enemy is dispatched. Tincture 'Merthiolate' (Sodium Ethyl Mercuri Thiosalicylate, Lilly), 1:1,000, is especially qualified for the "mop-up" detail. When Tincture 'Merthiolate' is applied, many nonsporulating pathogenic organisms are given the *coup de grâce* on contact. Stragglers which dare to rise from a hair follicle or which fall on the operative field from the air are also exposed to the germicidal action of the film of 'Merthiolate' on the skin. The low toxicity of 'Merthiolate' and its compatibility with body fluids recommend it as a safe, reliable skin disinfectant. Tincture 'Merthiolate' is available in leading hospitals and pharmacies everywhere.

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Volume 43
Number 5

THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Published Monthly Since September, 1904
Whole Number of Issues, 501

Under the
Direction of the
Committee on Publication

Henry C. Barkhorn, M.D., Chairman

Henry A. Davidson, M.D., Editor

Place of Publication, Printing and Mailing—12 South Day Street, Orange, N. J.
Editorial and Executive Offices of the Society—315 West State Street, Trenton 8, N. J.; Tel. 5776
Send all communications to the Trenton Office.
Each member of the State Society is entitled to receive a copy of The Journal every month.

Vol. 43, No. 5 May, 1946 Subscriptions, $3.00 per Year
Single Copies, 30 Cents

THE PAUSE THAT REFRESHES

A quick vacation with a clear conscience . . . that's one way of characterizing a medical convention. Your conscience is clear, because after all, isn't the Annual Meeting the place where you sharpen your professional skills? You've had a busy year and with spring pouring in through the office window, a three-day vacation in Atlantic City sounds like the pause that refreshes. But conscience raps and says you can't afford the time. Ah, here's the beauty of it. You tell conscience that you are really going to Atlantic City to improve your mind, to learn about the newer miracles of modern medicine. You don't have to tell conscience about the boardwalk and the bathing, the sense of millionaire relaxation that comes with a rolling-chair ride; nor need you tell of the salt air or the salt-water taffy either. Who will complain if you forget to mention the fishing, the cocktail party, and the passing parade on the sun-drenched boardwalk? If you have ears to hear, there will be speeches on the progress of medicine, talks packed with tips on treatment, and practical suggestions on diagnosis. And if you have eyes to see, there will be exhibits of new drugs and new appliances. And of course more free samples than you can pack into your rumble seat. If you occasionally slip out of a solemn scientific session to inhale the famous Atlantic County ozone, there will be no one to reprove you, except your equally guilty colleagues pounding the pines over the beach front. After all, you'll be telling yourself, you can always read the speeches later in *The Journal.* And on Wednesday evening, stuffed with good-will, cocktails and a banquet, you'll be sitting in on the social high-spot of the convention.

Yes, there is more to a medical convention than a diet of scientific papers. The pleasant break in the daily design for living, the chance, for the nonce, of getting the nose away from that grindstone. The sun and the breeze and the air and reunion with old friends.

Long Island now houses the parliament of man. We wish them well and begrudge them not the honor. Let them keep the world's workshop, so long as we in New Jersey have the world's playground right at our back door. For in the words of the old Farmer's Almanac, "In May we play and make good cheer; for Maytime comes but once a year!"

THE 180th ANNUAL MEETING
of
THE MEDICAL SOCIETY OF NEW JERSEY
CLARIDGE HOTEL, ATLANTIC CITY
May 21, 22 and 23, 1946

OFFICIAL EVENTS

MONDAY, MAY 20, 1946

3:00 p. m.—Registration opens
All officers, delegates, members of component County Societies, guests, and exhibitors are requested to register at the Registration Desk at the entrance to the Exhibit Hall on the Mezzanine Floor, immediately upon arrival.

4:00 p. m.—Meeting of Finance and Budget Committee
Room 815, 8th floor

6:00 p. m.—Fellows' Dinner
Binnacle Room, 1st floor

6:30 p. m.—Judicial Councilors' Dinner
Chart Room, 1st floor

8:00 p. m.—Board of Trustees' Meeting
Room 815, 8th floor

TUESDAY, MAY 21, 1946

9:00 a. m.—Registration opens
Mezzanine floor

9:30 a. m.—Inspection of exhibits
Mezzanine floor

11:00 a. m.—House of Delegates
Cambridge Hall, Mezzanine floor

1:00 p. m.—Luncheon, New Jersey College of Chest Physicians
Chart Room, 1st floor

1:00 p. m.—Auxiliary Executive Board Meeting
Binnacle Room, 1st floor

2:00 p. m.—General Session
Cambridge Hall, Mezzanine floor

4:00 p. m.—Auxiliary Rolling Chair Ride
Boardwalk

4:30 p. m.—Inspection of Exhibits
Mezzanine floor

7:30 p. m.—Auxiliary Fellowettes' Dinner
Shelburne Hotel

8:00 p. m.—Reference Committees' Meetings
Cambridge Hall, Mezzanine floor

8:30 p. m.—Nominating Committee Meeting
Chart Room, 1st floor

WEDNESDAY, MAY 22, 1946

8:00 a. m.—Auxiliary President's Breakfast
Stratosphere Room, Traymore Hotel

9:00 a. m.—Registration opens
Mezzanine Floor

9:00 a. m.—Inspection of Exhibits
Mezzanine floor

9:30 a. m.—Auxiliary Business Session
Belvidere Room, Traymore Hotel

9:30 a. m.—Scientific Section Meetings:
Medicine
Cambridge Hall, Mezzanine floor
Eye, Ear, Nose and Throat
East Lounge, Mezzanine floor
Obstetrics and Gynecology
Binnacle Room, 1st floor
Radiology
Chart Room, 1st floor

12:30 p. m.—House of Delegates (election)
Cambridge Hall, Mezzanine floor

1:00 p. m.—Luncheons:
Auxiliary
Rose Room, Traymore Hotel
Committee on Maternal Welfare and Field Physicians
Main Dining Room, Mezzanine floor
Radiological Society of New Jersey
Main Dining Room, Mezzanine floor
Joint Committee on Professional Relations
Main Dining Room, Mezzanine floor
Jefferson Medical College Alumni
Club Room, Traymore Hotel
Gastro-Enterology and Proctology Section
Main Dining Room, Mezzanine floor
New Jersey Section, College of Physicians
Stratosphere Room, Traymore Hotel
New Jersey Society of Clinical Pathologists
Room 121, Ambassador Hotel

2:00 p. m.—Scientific Section Meetings:
Surgery
Cambridge Hall, Mezzanine floor
Pediatrics
Binnacle Room, 1st floor
Gastro-Enterology and Proctology
Chart Room, 1st floor

2:30 p. m.—New Jersey Society of Clinical Pathologists
East Lounge, Mezzanine floor

3:00 p. m.—Auxiliary Business Session, continued
Belvidere Room, Traymore Hotel

4:30 p. m.—Inspection of Exhibits
Mezzanine floor

5:00 p. m.—Social Session
Cambridge Hall, Mezzanine floor

7:30 p. m.—Banquet
Cambridge Hall, Mezzanine floor

10:30 p. m.—Dancing and Entertainment
Cambridge Hall, Mezzanine floor

THURSDAY, MAY 23, 1946

9:00 a. m.—Registration opens
Mezzanine floor

9:30 a. m.—Inspection of Exhibits
Mezzanine floor

10:00 a. m.—General Session
Cambridge Hall, Mezzanine floor

10:30 a. m.—Auxiliary Executive Board Meeting
Binnacle Room, 1st floor

1:30 p. m.—House of Delegates
Cambridge Hall, Mezzanine floor

GENERAL SESSIONS

Tuesday Afternoon, May 21, 1946
Cambridge Hall, Mezzanine Floor

2:00 p. m.

Medical Progress and Medical Education During the War
Perrin H. Long, M.D., Professor of Preventive Medicine, The Johns Hopkins University School of Medicine, Baltimore

3:00 p. m.

The Third Phase of Medical Care
Howard A. Rusk, M.D., Consultant in Physical Rehabilitation to the Baruch Committee on Physical Medicine, New York

Thursday Morning, May 23, 1946
Cambridge Hall, Mezzanine Floor

10:00 a. m.

Medical Economic Problems of Today and Tomorrow and Organized Medicine's Answer to These Problems
William B. Rawls, M.D., New York

11:00 a. m.

Recent Advances in Cancer Research
Cornelius P. Rhoads, M.D., Director, Memorial Hospital, New York City

SECTION MEETINGS

Wednesday Morning, May 22, 1946

MEDICINE

JOHANNES F. PESSEL, M.D., Chairman
ANDREW J. V. KLEIN, M.D., Secretary

Cambridge Hall, Mezzanine Floor

9:30 a. m.

The Neurological and Psychological Problems of the Post-War Veteran and His Family
Joseph C. Yaskin, M.D., Professor of Neurology, Graduate School of Medicine, University of Pennsylvania, Philadelphia
Discussion to be opened by:
Theodore R. Robie, M.D., East Orange
Earl Fuller, M.D., Greystone Park

Relapsing Tropical Diseases and Their Treatment
Edgar A. Lawrence, M.D., Lt. Col. A.A.F., Division Chief of Preventive Medicine, China-Burma-India Theater of War; Instructor of Medicine, Cornell Medical College, New York
Discussion to be opened by:
Christian P. Segard, M.D., Leonia

What Can Be Done Toward Reducing the High Incidence and the High Mortality Rate of Cardiac Disease?
William D. Stroud, M.D., Professor of Cardiology, University of Pennsylvania, Philadelphia
Discussion to be opened by:
Charles D. Driscoll, M.D., West Collingswood
Ralph K. Hollinshed, M.D., Westville

OBSTETRICS AND GYNECOLOGY

HOWARD C. CURTIS, M.D., Chairman
ALBERT B. DAVIS, M.D., Secretary

Binnacle Room, 1st Floor

9:30 a. m.

Management of Premature Labor
Robert A. MacKenzie, M.D., Asbury Park
Discussor:
Raymond T. Potter, M.D., East Orange

Maternal Mortality (Its Preventable Aspects)
James F. Norton, M.D., Jersey City
Discussor:
Frank J. Hughes, M.D., Camden

The Present Status of Caudal Analgesia and Anesthesia in Obstetrics
John C. Hirst, M.D., Associate Professor, Obstetrics and Gynecology, Graduate School of Medicine, University of Pennsylvania, Philadelphia
Discussor:
Abraham Shulman, M.D., Paterson

Measures for the Protection of New Born Infants—Full Term and Premature
Charles A. Weymuller, M.D., Professor of Pediatrics, Long Island College of Medicine, Brooklyn
Discussor:
Vincent P. Del Duca, Camden

RADIOLOGY

HARRY J. PERLBERG, M.D., Chairman
HARRY R. BRINDLE, M.D., Secretary

Chart Room, 1st Floor

9:30 a. m.

Congenital Obstruction in the Alimentary Tract of the Newborn
John P. Caffey, M.D., Associate Professor of Pediatrics, College of Physicians and Surgeons, Columbia University, New York

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EYE, EAR, NOSE AND THROAT

GEORGE P. MEYER, M.D., Chairman
JOHN P. BRENNAN, M.D., Secretary

East Lounge, Mezzanine Floor

9:30 a. m.

Recent Advances in Ocular Therapy
Irving H. Leopold, M.D., Instructor of Ophthalmology, University of Pennsylvania, Philadelphia

War Casualties in an Army Eye Center
M. Elliott Randolph, Lt. Col., M.C., U.S.A.

SYMPOSIUM

Aural Rehabilitation in the Navy
a. Medical Aspects
Fred Harbert, Captain, U.S.N.
b. Auditory Testing and Hearing Aids
Eva Thompson, Lt., U.S.N.
c. Retaining Program and Speech Reading
Margaret Paul, Lt., U.S.N.
d. Organization and Facilities
W. G. Hardy, Lt., U.S.N.

Wednesday Afternoon, May 22, 1946

SURGERY

John C. Cox, M.D., Chairman
Francis M. Clarke, M.D., Secretary

Cambridge Hall, Mezzanine Floor

2:00 p. m.

Carcinoma of the Rectum
Damon B. Pfeiffer, M.D., Director of Pfeiffer Surgical Clinic, Abington Memorial Hospital, Abington, Pa.

Discussors:
Edward W. Sprague, M.D., Newark
Homer I. Silvers, M.D., Atlantic City

Venous Thrombosis and Pulmonary Embolism—Its Diagnosis and Treatment
Robert R. Linton, M.D., Visiting Surgeon and Chief of the Peripheral Vascular Clinic, Massachusetts General Hospital, Boston

Discussor:
Joseph C. Vargyas, M.D., New Brunswick

Surgery of the Sympathetic Nervous System in Hypertensive Patients
Reginald H. Smithwick, M.D., Professor of Surgery, Harvard University, Boston, Mass.

Discussor:
Edward A. Cannon, M.D., North Bergen

PEDIATRICS

Samuel Blaugrund, M.D., Chairman
L. C. Victor duBusc, M.D., Secretary

Binnacle Room, 1st Floor

2:00 p. m.

PANEL DISCUSSION

A Clinical Discussion of Rheumatic Fever and Rheumatic Heart Disease
William D. Stroud, Professor of Cardiology, University of Pennsylvania, Philadelphia

Potentialities in the School Health Program for the Control of Rheumatic Fever
George M. Wheatley, M.D., Assistant Medical Director, Metropolitan Life Insurance Company, New York

Experience with Initiating a Community Program on Rheumatic Fever
J. G. Fred Hiss, M.D., Professor of Clinical Medicine, Syracuse University, Syracuse

Experience with Initiating State Programs for the Control of Rheumatic Fever
Betty Huse, M.D., Assistant Director, Division of Health Service, Children's Bureau, U. S. Department of Labor, Washington, D. C.

GASTRO-ENTEROLOGY AND PROCTOLOGY

S. Bernard Kaplan, M.D., Chairman
Louis L. Perkel, M.D., Secretary

Chart Room, 1st Floor

2:00 p. m.

Intestinal Parasitism in an Army Hospital
Manfred Kraemer, M.D., Newark
Discussor:
Andrew J. V. Klein, M.D., Newark

Esophageal Hiatus Hernia
Louis L. Perkel, M.D., Jersey City
Discussor:
Herbert Greenfield, M.D., Newark

Animo Acids in Ulcer Therapy
Frank W. Co Tui, M.D., Research Professor in Surgery, Bellevue Hospital, New York
Discussor:
Sigurd W. Johnsen, M.D., Passaic

Management of Common Ano-Rectal Conditions
Jacob L. Mathesheimer, M.D., Jersey City
Discussor:
Julius Gerendasy, M.D., Elizabeth

BANQUET AND BALL

in honor of PRESIDENT AND MRS. SAMUEL ALEXANDER

Hostesses: The Woman's Auxiliary to The Medical Society of New Jersey

Wednesday, May 22, 1946

7:30 p. m.

Cambridge Hall, Mezzanine Floor

Toastmaster: Dr. Hilton S. Read

Welcome: Mrs. William E. Dodd, President, Woman's Auxiliary to The Medical Society of New Jersey

Dr. Samuel Alexander, President, The Medical Society of New Jersey

Introductions: Mrs. Frederick G. Wandall, President-Elect, Woman's Auxiliary to The Medical Society of New Jersey

Dr. Frank G. Scammell, President-Elect, The Medical Society of New Jersey

Presentation of Fellow's Key:
To: Dr. Samuel Alexander, President
By: Dr. Joseph F. Londrigan, Junior Past-President

Guest Speaker:
Progress in Reorganization of the Medical Service of the Veterans Administration
Major General Paul R. Hawley, Chief Medical Director, Department of Medicine and Surgery, Veterans Administration, Washington

Following the banquet, dancing, entertainment and beverages will be available in Cambridge Hall for your enjoyment.

LUNCHEONS AND DINNERS

Monday, May 20, 1946

6:00 p. m.—Fellows of The Medical Society of New Jersey
Binnacle Room, 1st Floor
For reservation, contact the Executive Offices, Trenton, N. J.

6:30 p. m.—Judicial Councilors of The Medical Society of New Jersey
Chart Room, 1st Floor
For reservation, contact the Executive Offices, Trenton, N. J.

Tuesday, May 21, 1946

1:00 p. m.—New Jersey Section, College of Chest Physicians
Chart Room, 1st Floor
For reservation, contact Dr. Harold S. Hatch, Box 370, Morristown, N. J.

7:30 p. m.—Fellowettes of the Woman's Auxiliary to The Medical Society of New Jersey
Shelburne Hotel
For reservation, contact Mrs. David B. Allman, 104 St. Charles Place, Atlantic City, N. J.

Wednesday, May 22, 1946

1:00 p. m.

Woman's Auxiliary to The Medical Society of New Jersey
Traymore Hotel
For reservation, contact Mrs. G. Ruffin Stamps, 300 East Verona Avenue, Pleasantville, N. J.

Committee on Maternal Welfare and Field Physicians
Main Dining Room, Mezzanine Floor
For reservation, contact the Executive Offices, Trenton, N. J.

Radiological Society of New Jersey
Main Dining Room, Mezzanine Floor
For reservation, contact Dr. Harry R. Brindle, 501 Grand Avenue, Asbury Park, N. J.

Joint Committee on Professional Relations
Main Dining Room, Mezzanine Floor
For reservation, contact Dr. Reeve L. Ballinger, 659 Kearny Avenue, Arlington, N. J.

Jefferson Medical College Alumni Association
Traymore Hotel
For reservation, contact Dr. Harold S. Davidson, 117 South Illinois Avenue, Atlantic City, N. J.

College of Physicians, New Jersey Members
Traymore Hotel
For reservation, contact Dr. J. F. Pessel, 224 West State Street, Trenton, N. J.

New Jersey Society of Clinical Pathologists
Room 121, Ambassador Hotel
For reservation, contact Dr. S. A. Goldberg, Presbyterian Hospital, Newark, N. J.

Gastro-Enterology and Proctology Section
Main Dining Room, Mezzanine Floor
For reservation, contact Dr. S. William Kalb, 416 Clinton Place, Newark, N. J.

7:30 p. m.

BANQUET
Cambridge Hall, Mezzanine Floor
For reservation, contact the Executive Offices, Trenton, N. J.

NOMINATING COMMITTEE

Tuesday Evening, May 21, 1946, 8:30 P. M.

Chart Room, 1st Floor

Chairman, JOSEPH F. LONDRIGAN, M.D., Junior Past-President

County	*Delegate*	*Alternate*
ATLANTIC	D. Ward Scanlan	David B. Allman
BERGEN		
BURLINGTON	Daniel F. Remer	Parry M. Scott
CAMDEN	Thomas K. Lewis	H. Wesley Jack
CAPE MAY	Clarence W. Way	George F. Dandois
CUMBERLAND	H. Burton Walker	H. Garrett Miller
ESSEX	H. Roy Van Ness	William H. Areson
GLOUCESTER	Baxter A. Livengood	Wendell J. Burkett
HUDSON	James F. Norton	J. Lawrence Evans
HUNTERDON	Barclay S. Fuhrmann	Samuel B. English
MERCER	Harry R. North	D. Leo Haggerty
MIDDLESEX	W. Edgar Sherman	William C. Wllentz
MONMOUTH	William G. Herrman	Granville L. Jones
MORRIS	Bernard C. McMahon	F. Clyde Bowers
OCEAN	Blackwell Sawyer	William E. Dodd
PASSAIC	Charles J. Murn	Louis J. Bohl
SALEM	Frank L. Perry	
SOMERSET	Runkle F. Hegeman	Samuel H. Pogoloff
SUSSEX	Joseph G. Coleman	Frederick H. Morrison
UNION	Thomas J. Walsh	Frederic W. Lathrop
WARREN	Harry B. Bossard	Floyd A. Shimer

REFERENCE COMMITTEES

Tuesday Evening, May 21, 1946, 8:00 P. M.

Cambridge Hall, Mezzanine Floor

Reference Committee "A", to consider reports of:
The President
The Board of Trustees
The Secretary
The Judicial Council

Frederic W. Lathrop, Chairman..Union County
William D. Crecca .....Essex County
Harrison B. Wilson .....Bergen County
Reeve L. Ballinger .....Hudson County
Charles J. Murn .....Passaic County

Reference Committee "B", to consider reports of:
The Treasurer
The Finance and Budget Committee
The Publication Committee

Daniel F. Remer, Chairman..Burlington County
Edward W. Sprague .....Essex County
Thomas McG. Brennock .....Hudson County
Herschel S. Murphy .....Union County
Joseph G. Coleman .....Sussex County

Reference Committee "C", to consider reports of:
The Medical Service Administration
The Medical-Surgical Plan
The State Board of Medical Examiners

Sigurd W. Johnsen, Chairman..Passaic County
James F. Norton .....Hudson County
J. Wallace Hurff .....Essex County
H. Wesley Jack .....Camden County
Joseph H. Kler .....Middlesex County

Reference Committee "D", to consider reports of:
The Post-Graduate Education Committee
The Scientific Work Committee
The Medical Defense and Insurance Committee
The Advisory Committee to Woman's Auxiliary

David B. Allman, Chairman....Atlantic County
Harry N. Comando .....Essex County
Floyd A. Shimer .....Warren County
William E. Dodd .....Ocean County
Louis J. Bohl .....Passaic County

Reference Committee "E", to consider reports of:
The Welfare Committee
The Subcommittees to the Welfare Committee
The Advisory Committees to the Subcommittees of the Welfare Committee

Henry C. Barkhorn, Chairman....Essex County
Robert A. MacKenzie .....Monmouth County
Ralph J. Faulkingham .....Middlesex County
Hammell P. Shipps .....Burlington County
Spencer T. Snedecor .....Bergen County

Reference Committee on Constitution and By-Laws:
Royal A. Schaaf, Chairman .....Essex County
D. Ward Scanlan .....Atlantic County
George F. Dandois .....Cape May County
Samuel Blaugrund .....Mercer County
Chester I. Ulmer .....Gloucester County

Reference Committee on Miscellaneous Business, to consider also reports of:
The Annual Meeting Committee
The Subcommittee on Scientific Program
Place and Date of 1947 Annual Meeting

David W. Green, Chairman .....Salem County
H. Burton Walker .....Cumberland County
William C. Wilentz .....Middlesex County
Francis C. Weber .....Essex County
Baxter A. Livengood .....Gloucester County

Reference Committee on Resolutions and Memorials, and to consider report of:
The Committee on Honorary Membership

Samuel A. Cosgrove, Chairman..Hudson County
D. Leo Haggerty .....Mercer County
F. Clyde Bowers .....Morris County
Lorrimer B. Armstrong .....Union County
Francis B. Brogan .....Passaic County

Reference Committee on Credentials
Thomas B. Lee, Chairman.....Camden County
Alfred Stahl, Secretary, Ex-officio, Essex County
George J. Young, Treasurer, Ex-officio
Morris County

HOUSE OF DELEGATES

Presiding Officer, SAMUEL ALEXANDER, M.D., President, Park Ridge
Secretary, ALFRED STAHL, M.D., Newark

The Committee on Credentials will meet at the Registration Desk on Monday afternoon and on Tuesday, Wednesday and Thursday mornings.

Cambridge Hall, Mezzanine Floor

First Session, 11:00 a. m., Tuesday, May 21, 1946

Order of Business

a. Call to Order
b. Organization of House of Delegates
c. Minutes of 1944 and 1945 Meetings
d. Introduction of Delegates from Other States
e. Annual and Supplemental Reports

Second Session; 12:30 p. m., Wednesday, May 22, 1946

Order of Business

a. Report of Nominating Committee
b. Election

Third Session; 1:30 p. m., Thursday, May 23, 1946

Order of Business

a. Reports of Reference Committees
b. Unfinished Business
c. Inauguration of Incoming President, Frank G. Scammell, M.D.
d. Adjournment

WOMAN'S AUXILIARY TO THE MEDICAL SOCIETY OF NEW JERSEY

NINETEENTH ANNUAL MEETING

PROGRAM

Tuesday, May 21, 1946

10:00 a. m.—Registration — Luncheon and Dinner Tickets
Elevator Foyer, Mezzanine Floor

1:00 p. m.—Executive Board Meeting, Mrs. William E. Dodd, President, presiding
Binnacle Room, 1st Floor

4:00 p. m.—Rolling Chair Ride
Boardwalk

7:30 p. m.—Fellowettes' Dinner, Mrs. David B. Allman, Junior Past-President, Chairman
Shelburne Hotel

Wednesday, May 22, 1946

9:30 a. m.—Business Session, Mrs. William E. Dodd, President, presiding
Belvidere Room, Traymore Hotel
Order of Business:
a. Invocation: Rev. J. Stanley Wagg, St. Paul's Methodist Church, Atlantic City
b. Greeting: Mrs. Robert A. Bradley, President, Woman's Auxiliary to the Atlantic County Medical Society
c. Response: Mrs. Frederick G. Wandall, President-Elect
e. Organization
f. Memorial Services for Departed Members, Mrs. George A. Rogers, Fellowette, 1937
g. Reports
h. New Business

1:00 p. m.—Luncheon honoring Mrs. William E. Dodd, President (Fee $2.50)
Rose Room, Traymore Hotel
Toastmistress: Mrs. Asher Yaguda
Welcome: Mrs. William E. Dodd, President, Woman's Auxiliary to The Medical Society of New Jersey
Greetings: Dr. Samuel Alexander, President, The Medical Society of New Jersey
Speaker: Dr. Ivor Griffith, President, Philadelphia College of Pharmacy and Science
Presentation of President's Pin:
To: Mrs. William E. Dodd, President
By: Mrs. A. Haines Lippincott, Senior Past-President
Entertainment: Frank Nicolleta, Harpist

3:00 p. m.—Business Session, continued
Belvidere Room, Traymore Hotel
Order of Business:
a. Unfinished Business
b. Report of Nominating Committee
c. Election of Officers
d. Inauguration of Incoming President, Mrs. Frederick G. Wandall
e. Installation of Officers

5:00 p. m.—Social Session
Cambridge Hall, Mezzanine Floor

7:30 p. m.—Banquet in honor of President Samuel Alexander, M.D., The Medical Society of New Jersey (Fee $4.00)
Cambridge Hall, Mezzanine Floor

10:30 p. m.—Dancing and Entertainment
Cambridge Hall, Mezzanine Floor

Thursday, May 23, 1946

10:30 a. m.—New Executive Board Meeting, Mrs. Frederick G. Wandall, President, presiding
Binnacle Room, 1st Floor

EDUCATIONAL EXHIBITS

Mezzanine Floor

Booth 5—Cancer—Sponsored by the Advisory Committee on Cancer Control, The Medical Society of New Jersey; American Cancer Society, New Jersey Division; New Jersey State Department of Health and the New Jersey State Department of Institutions and Agencies.—"The Private Physician Sees the Cancer Patient First" is the keynote of this exhibit which features the equipment and procedures which can be used for preliminary examinations in the office of the physician. A manikin shows the number and percentage of deaths from cancer by organ affected for males and females in New Jersey. Tables show what can be gained for the cancer patient by early diagnosis. Maps and charts summarize *results* of the Cancer Survey of organized diagnostic and treatment facilities by counties, in New Jersey; the Survey was a joint project held under the auspices of the Sponsors of the present exhibit. Display designed and erected by Health Education Division, Bureau of Preventable Diseases, New Jersey State Department of Health.

Booth 5-A—New Jersey Formulary Exhibit presented by the Joint Committee on Professional Relations of The Medical Society of New Jersey and the New Jersey Pharmaceutical Association.—To supplement the publicity material New Jersey physicians have been receiving regularly during the past few years, the Joint Committee will display a complete line of finished New Jersey Formulary preparations. Two recently adopted formulas for *Hydrophylic Ointment* and *Hydrophylic Petrolatum* will be shown for the first time, with descriptive literature explaining the properties and usefulness of the products. Members of the Joint Committee will be in attendance to assist visiting physicians in becoming better acquainted with the New Jersey Formulary program and what it is intended to accomplish in fostering coöperation between physicians and pharmacists in the interest of public welfare.

TECHNICAL EXHIBITS

Mezzanine Floor

Technical Exhibitors have an unusual program to show this year. With many of the war restrictions lifted, these displays will be exceptionally eye-catching, instructive and interesting. Most of the exhibitors have been with us each year and you will find personal friends who have served you faithfully in the past and will continue to do so in the future. You will need their help and you can help them by this show of interest. Be sure to register at the Technical Exhibit Booths.

COMMITTEE ON ANNUAL MEETING.

Booth 1—G. D. Searle & Co., Chicago—You are cordially invited to visit the Searle booth where representatives will be happy to answer questions pertaining to Searle Products of Research. Featured will be Searle *Aminophyllin, Metamucil, Ketochol, Floraquin, Diodoquin, Pavatrine, Tetrathione,* and *Gonadophysin.*

Booth 2—White Laboratories, Inc., Newark—White Laboratories, Inc., present information regarding White's *Sulfathiazole Gum*—expressly formulated for topical chemotherapy in oropharyngeal infections; White's *Otomide*—a more effective means of topical chemotherapy in ear infections—and a NEW specialty, White's *Mol-Iron Tablets,* a new and definite advance in the treatment of iron deficiency anemias. White's ethically promoted vitamin specialties are also featured. You will find a very cordial welcome by White's Medical Service Representatives in charge of the exhibit.

Booth 3—Philip Morris & Co., Ltd., Inc., New York—Philip Morris & Company will demonstrate the method by which it was found that Philip Morris Cigarettes, in which *diethylene glycol* is used as the hygroscopic agent, are less irritating than other cigarettes. Their representative will be happy to discuss researches on this subject, and problems on the physiologic effects of smoking.

Booth 4 — Novocol Chemical Mfg. Co., Inc., Brooklyn, N. Y.—Demonstrating *Monocaine,* the new, safe, potent anesthetic in both aqueous and oil solutions. Time tried and clinically proved dependable preparations for every physician. The 1½ per cent solution with epinephrin is daily gaining in popularity with the exacting practitioner. Faster induction and better tolerance are features making *Monocaine* the anesthetic of preference. Available in Anestubes (metal cap cartridges), ampules, Novoampuls, and bottles. Also displayed will be Therapules (metal cap cartridges) filled with estrogenic substances in oil, narcotic solutions as well as solutions very frequently employed for circulatory and respiratory stimulation. Our representative will be happy to discuss our products with you.

Booth 6—Cameron Surgical Specialty Co., Chicago—At the Cameron Surgical Specialty Company's booth you may place your orders (for delivery within 20 days) for the finest electrically lighted diagnostic instruments in the world. Immediate delivery now of *Omniangle Flexible Gastroscopes.* Radio cutting and coagulation units in all sizes. See the first all bollable, stainless steel bronchoscopic outfit.

Booth 7 — Schenley Laboratories, Inc., New York—The Schenley Laboratories' exhibit is devoted entirely to *penicillin* and penicillin products. A series of trans-illuminated Kodachromes of various pyogenic skin infections shows the therapeutic efficacy of *Penicillin Ointment Schenley.* A well-informed attendant will gladly discuss any phase of penicillin therapy and developments with interested physicians. Executive Offices: 350 Fifth Ave., New York, N. Y.

Booths 8 & 9 — Mead Johnson & Company, Evansville, Ind.—*"Servamus Fidem"* means We Are Keeping the Faith. Almost every physician thinks of Mead Johnson & Company as the maker of *Dextri-Maltose, Pablum, Oleum Percomorphum,* and other infant diet materials—including the new precooked oatmeal cereal, *Pabena.* But not all physicians are aware of the many helpful services this progressive company offers physicians. A visit to booths 8 and 9 will be time well spent.

Booth 10—Faulhaber & Heard, Inc., Newark, N. J.—Many physicians on resumption of private practice following release from government service have arranged with Faulhaber & Heard, Inc., Official Broker of The Medical Society of New Jersey, to restore their professional liability protection. If you have resumed practice or contemplate doing so in the near future, file your application at booth 10, or write to Faulhaber & Heard, Inc., 31 Clinton Street, Newark 2, N. J., in order that this protection may become effective when needed.

Booth 11—E. & W. Blanksteen, Jersey City, N. J.—The Medical Society of New Jersey Group Plan of Accident and Health Insurance is now on an individually non-cancellable group plan basis. It is underwritten by the National Casualty Company through our authorized accident and health insurance representatives, E. & W. Blanksteen, 76 Montgomery Street, Jersey City, N. J. New members and those returning from military service have 60 days from the date of their election to membership or return from military service, in which to apply and be sure of being included in the group program regardless of past medical or insurance history or present physical impairment. Other members who have not yet joined the group may still apply and be included if their applications meet the company's underwriting requirements.

Booth 12—F. E. Young & Co., Chicago—Manufacturers of *Young's Rectal Dilators.* The adult set consists of a series of four bakelite dilators graduated in size and introduced in series as the anal

sphincter becomes accustomed to dilatation. An infant's and children's set is also supplied which consists of a series of four bakelite dilators graduated in size. Largest in this size is equivalent to the second size in the adult set. Rectal dilators are used by physicians to treat certain cases of constipation, hemorrhoids, rectal neurosis, pruritus ani, dysmenorrhea, uncomfortable bowel movements and other conditions which arise due to tight or spastic anal sphincter muscles. They are used in children with an atonic colon in association with a spastic anal sphincter and also post-operatively.

Booth 13—L. & B. Reiner, New York—On display in booth 13 will be two items of interest to every physician. The *EPL Cardiotron* Direct-Recording electrocardiograph will be in actual operation. Come in and let us show you how you can take standard electrocardiograms, recorded instantaneously and permanently. Also on display will be the latest model of the *Jones motor-basal metabolism* apparatus. We should like the opportunity to explain some of the exclusive features of the *Jones* which include an automatic check on accuracy, simplified calculation eliminating all mathematics and the use of barometer or thermometer, and complete patient comfort. Ask about *Windar.*

Booth 14—Endocrine Company, Union City—Featuring from its many effective Endocrin and Vitamin products, an advanced formula for better calcium therapy; the highest potency liquid concentrate of pure *Thiamin* as an alternate to all too often painful thiamin injection; and the new aqueous suspension of *Estrogenic Hormone.*

Booth 15—The Borden Company, New York—Spend a few minutes with Borden at booth 15 . . . refresh your memory on our prescription products! Meet the new concentrated *Biolac;* New Improved *Dryco* with its formula flexibility; *Mull-Soy* for your milk allergic patients; powdered whole milk *Klim;* the improved milk sugar *Beta Lactose;* and the *Merrell-Soule Protein* and *Lactic Acid Milks.* Borden men are pleasant men!

Booth 16—Parke, Davis & Co., Detroit—Representatives of Parke, Davis & Co., well informed concerning progress in pharmaceutical research, and desirous of presenting new advancements to you, will be in attendance at our technical exhibit to discuss the nature and use of our new and present products. Displayed will be such outstanding products as *Theelin, Mapharsen,* and *Adrenalin Preparations.* The latest type of biologic products will be on display, including our exclusive *Despeciated Antitoxins.* Also, *Penicillin* and other therapeutic agents and antibiotic, biologic, and chemotherapeutic interest will be shown. We sincerely invite your visit to this Exhibit.

Booth 17—Hanovia Chemical and Manufacturing Company, Newark, N. J.—Hanovia booth 17 will display a complete line of ultraviolet quartz lamps for general therapeutic and bactericidal application. Don't fail to witness a demonstration of the *Aero-Kromayer Lamp* designed for localized application.

Booth 18—Doho Chemical Corporation, New York, N. Y.—The makers of *"Auralgan"* are introducing at this meeting their new sulfa drug preparation *"Otosmosan,"* indicated in the treatment and control of chronic suppurative ears. Our representatives will be happy to explain, in detail, the workings of these medications. Also, to distribute our latest series of three (3) Anatomico-Pathologic Charts of the Ear, in color, suitable for framing.

Booth 19—H. J. Heinz Co., Pittsburgh—H. J. Heinz Company is displaying and sampling their Strained and Junior Foods in glass. Latest addition to this line is *Pre-Cooked Cereal Food,* a new easily-prepared toasted cereal. It contains wheat, corn and oats together with wheat germ and corn germ. For further enrichment di-calcium phosphate, calcium carbonate and vitamin B complex have been added. Their representatives would appreciate your suggestions and remarks about these products. They are presenting a new publication, *The Nutritive Value of Vegetables.* Examine, then register for it. A reminder: register for the 11th edition *Nutritional Chart, Nutritional Observatory, Special Dietary Foods Book,* and an office supply of *Your Baby's Diary and Calendar.*

Booth 20—Ortho Pharmaceutical Corporation, Linden, N. J.—Ortho Pharmaceutical Corporation will exhibit their Gynecic Pharmaceutical specialties, including *Ortho-Gynol, Ortho-Creme,* and *Ortho Diaphragms* for the control of conception, *Nutri-Sal* for selected cases of infertility, *Hexital* for the menopause, *Hexestrol* for oral estrogenic therapy, *Aci-jel* for vaginal infections, and *Triple Sulfa* for bacterial vaginal infections.

Booth 21—Schering Corporation, Bloomfield, N. J.—The Schering exhibit will feature the latest developments in endocrine therapy, radiographic aids and other pharmaceutical advances. Of particular interest is the presentation of Combisul-TD. Combisul-TD is a sulfonamide combination based upon the now proved therapy which offers the therapeutic benefits of sulfathiazole and sulfadiazine with a material decrease in the danger of renal toxicity and crystalluria. Schering professional service representatives will be present to answer inquiries and to provide valuable, informative literature.

Booth 22—Eli Lilly and Company, Indianapolis.—The Lilly exhibit will feature an interesting demonstration in miniature on penicillin culture. Many Lilly products will be on display, and attending Lilly medical service representatives will be present to assist visiting physicians in every possible way.

Booth 23—Lederle Laboratories, Inc., New York—Lederle Laboratories extends to you a cordial invitation to visit exhibit space 23 where Lederle representatives will be in attendance to extend every courtesy in making available to you recent information on not only already accepted products, but on recent scientific developments, clinically tested and released for your consideration. We invite your attention to: *Ledercillin* (Brand of Penicillin) Lozenges—Tablets—Ointment Opthalmic and Penicillin

(Injectable); *Polligens* (for diagnosis and treatment of Hay Fever); *Poison Ivy Extract* or *Poison Oak Extract* (for prevention and treatment of Rhus Dermatitis); *Deracil—Anti Rh Serum—Intrapheptol—Rhinazine Benzestrol—Natural Estrogens* and *Diethylstilbestrol.* We shall appreciate your requests for literature which will receive our careful attention.

Booth 24—Smith, Kline & French Laboratories, Philadelphia—Benzedrine Sulfate Tablets, N.N.R. and Dexedrine Sulfate Tablets are featured at this exhibit. Since its introduction some ten years ago, *Benzedrine Sulfate,* N.N.R. (racemic amphetamine sulfate) has grown steadily in clinical usefulness and today occupies a unique place in routine medical practice. For certain selected cases, however, it is often desirable to employ a drug combining an even more preponderant central nervous stimulation with a relatively weaker peripheral effect. A closely related compound—*Dexedrine Sulfate* (dextro-amphetamine sulfate)—precisely fulfills these requirements. Our specially trained professional representatives will be glad to answer questions concerning the possible uses of our products in your practice.

Booth 25—Spencer, Incorporated, New Haven, Conn.—You are cordially invited to visit our exhibit, featuring Spencer individually designed supports for abdomen, back, and breasts. Doctors will be especially interested in these supports for patients who have undergone mastectomy. They will also be interested in the *Spencer Spinal Support* for patients following cast removal or, as an aid to treatment of protruding disc, and other back derangements. Supports for patient with hernia, visceroptosis with symptoms, postoperative needs, obesity, antepartum and postpartum needs are also on display.

Booth 26 — Pet Milk Company, St. Louis—A complete display of material illustrating the time-saving *Pet Milk* services available to physicians. Specially trained representatives will be in attendance to give you information about the production of Pet Milk and its use for infant feeding. Miniature cans will be given to physicians visiting the exhibit.

Booth 27—Bilhuber-Knoll Corp., Orange, N. J.—Among our fine medicinal chemicals on display at booth 27 are: *Metrazol*—circulatory and respiratory restorative and stimulant; *Dilaudid*—analgesic and cough sedative; *Octin*—antispasmodic in ureteral and like spasms, and useful other prescription chemicals in industrial medicine, such as *Bromural, Thocalcin, Phyllicin, Phenobarb.-Thocalcin* and *Potassium Iodid Thocalcin.* We invite your discussion of these every-day prescription chemicals.

Booth 28—National Dairy Council, New York—Physicians and surgeons are cordially invited to visit the National Dairy Council exhibit of health education materials at booth 28. Booklets, leaflets and posters giving timely and authentic nutrition information will be on display. This literature may be used for distribution to patients, in clinics, or for the reception room. Sample material will be available and may be requested.

Booth 29—M. & R. Dietetic Laboratories, Columbus, Ohio—M. & R. Dietetic Laboratories, booth 29, will display *Similac,* a food for infants deprived either partially or entirely of breast milk. Messrs. Manuel Goldwater and D. F. Schlosser will appreciate the opportunity to discuss the merit and suggested application for both the normal and special feeding cases.

Booth 30—Ciba Pharmaceutical Products, Inc., Summit, N. J.—Ciba invites all physicians to visit its display at booth 30. Among the many products exhibited will be *Privine HCl,* a potent nasal vasoconstrictor with prolonged action which has gained recognition in its field; *Metandren Linguets,* the most potent orally active androgen available in suitable form for sublingual use; *Trasentine,* a well tolerated antispasmodic with ability to abolish spasticities of the hollow abdominal viscera and *Trasentine-Phenobarbital,* a combination of the potent antispasmodic *Transentine* and the well-known sedative, Phenobarbital. For samples and literature on these and other products of Ciba manufacture, see our representative in attendance, who will be glad to answer your questions.

Booth 31—E. R. Squibb & Sons, New York—A technical exhibit intended to further the conservation and more effective use of *Penicillin.*

Booth 32—Gerber Baby Foods, Fremont, Mich.—Come in and see us at the Gerber's Baby Foods booth, where you can relax and discuss baby foods. Booklets are available on baby foods and on special diets for adults with tested recipes. Professional reference cards giving food values and chemical analyses of Gerber's Cereals. Gerber's Strained Foods, and Gerber's Chopped Foods are ready for your files. Samples of Gerber's Cereal Food and Gerber's Strained Oatmeal are also available.

Booth 33—Sharp & Dohme, Inc., Philadelphia—Sharp & Dohme will have their display at booth 33, featuring *Tyrothricin Concentrate* for human use, *Lyovac* normal human plasma, *Sulfasuxidine,* and *Caligesic Ointment,* a greaseless anesthetic and analgesic ointment which possesses definite antipruritic action. A cordial welcome awaits all visitors.

Booth 34—The Alkalol Co., Taunton, Mass.—The Alkalol Company is this year completing 50 years of service to the medical profession. The company manufactures two famous preparations: (1) *Alkalol*—a scientifically balanced alkaline, saline solution containing no glycerine and barely a trace of alcohol. It is hypotonic and a mucus solvent, and (2) *Irrigol*—an alkaline, saline douche powder which makes a nontoxic, slightly astringent solution, useful as a vaginal douche, rectal enema and for colonic irrigations.

Booth 35—Hoffmann-La Roche, Inc., Nutley, N. J.—Pharmaceutical prescription specialties of rare quality produced at Roche Park, where vitamins are made by the ton, will be exhibited. The medical profession's interest in *Per-os-cillin,* the

new stable oral penicillin ; the versatile parasympathetic stimulant *Prostigmin;* and other scientific accomplishments will be satisfied by Hoffmann-La Roche representatives who will be in attendance to discuss clinical problems.

Booth 36—The Mennen Company, Newark, N. J.—The Mennen Company will exhibit their two baby products—*Mennen Antiseptic Baby Oil* and *Mennen Antiseptic Baby Powder,* in addition to their fungicidal foot powder, *Quinsana.* The Antiseptic Oil is now being used routinely by the majority of the hospitals that are important in maternity work.

Booth 37—Holland-Rantos Company, Inc., New York—You are cordially invited to visit the Holland-Rantos booth where on display will be the nationally known and universally used *Koromex* contraceptive specialties. Besides the new Koromex Set Complete, which is a package combining the necessary items for complete contraceptive technique, there will be the new *Nylmcrate Jelly* introduced only a short time ago and received enthusiastically for the treatment of trichomoniasis and vaginal discharges of a non-specific origin. Representatives of the company will be on hand to answer all questions. Samples of Nylmerate Jelly and Koromex Jelly will be available, as will be copies of the *Dickinson Freret Charts.*

Booth 38—C. B. Fleet Co., Inc., Lynchburg, Va.—*Phospho-Soda (Fleet)* is the ethical saline eliminant. What may you, as a physician, expect from this stable, nontoxic concentrate of the two U. S. P. sodium phosphates? (1) Accurate dosage, regulated to the patient and to his condition. (2) The maximum therapeutic effectiveness of sodium phosphate. (3) Quick, gripeless evacuation, for emergencies. (4) Mild, controllable elimination, for chronic biliary disturbances and constipation. (5) Unusual freedom from after-irritation, with normalizing buffer action. (6) Safe action in the therapy of tropical diseases. Are you getting the full value of medication in your daily problems of elimination?

Booth A—The C. V. Mosby Company, St. Louis—The C. V. Mosby Company extends a cordial invitation to visit booth A, where medical publications of timely interest will be displayed. Our representative, Mr. F. W. Ganschow, will be glad to discuss your book needs with you.

Booth B—The Coca-Cola Company, Wilmington, Del.—Coca-Cola will be served through the joint courtesy of Coca-Cola Bottling Company of Atlantic City and The Coca-Cola Company.

Booth C — Nutrition Research Laboratories, Chicago—Nutrition Research Laboratories, booth C, will exhibit their ethical specialties, *Ertron, Ertron Parenteral, Infron Pediatric* and *Bezon* in an entirely new booth unit which incorporates Kodachrome transparencies of extreme interest to the medical profession. New clinical reprints and literature pertaining to all products will be available and competent representatives will be on hand at all times to greet members and guests of the Society.

TRAINS

Trains on the P.R.R. leave as follows:

	A.M.	A.M.	A.M.	A.M.	P.M.	P.M.	P.M.	P.M.
Jersey City	6:23	8:51	10:03	11:53	2:53	3:48	6:48	9:53
Newark	6:44	9:15	10:30	12:15	3:24	4:14	7:15	10:15
Elizabeth	....	....	10:38	....	....	....	....	....
New Brunswick	7:07	....	10:54	12:37	3:47	....	7:37	....
Trenton	7:33	10:00	11:23	1:01	4:18	4:59	8:05	11:04
North Philadelphia	8:30	10:47	....	1:48	....	5:39	8:52	12:14
Haddonfield	8:52	....	12:12	2:08	5:12	5:59	9:13	12:36
ARRIVE IN:								
	A.M.	Noon	P.M.	P.M.	P.M.	P.M.	P.M.	A.M.
Atlantic City	9:53	12:00	1:05	3:13	6:04	6:52	10:10	1:35

Trains leave Atlantic City at:

7:30 a. m., 8:30 a. m., 9:10 a. m., 10:30 a. m., 1:40 p. m., 3:00 p. m., 4:35 p. m., 6:35 p. m., and 10:00 p. m.

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FULL-TIME POSITIONS FOR M.D.'s

Salaries ranging from $3600 to $8700 a year are available to physicians interested in neuropsychiatry. The Veterans Administration has 31 vacancies immediately available in New Jersey. Ratings and salaries will be in accordance with the professional qualifications of the physician. Practitioners who are not trained in neuropsychiatry will be entitled to the training facilities of the new Department of Medicine and Surgery in the Veterans Administration. Interested applicants may obtain further details from Dr. Harold E. Foster, Veterans Hospital, Lyons, New Jersey. Other things being equal, preference will be given to doctors who have served in the Army or Navy. Nonveterans, however, are assured full consideration. Housing accommodations for both families and bachelors are or soon will be available on the hospital grounds.

THE MEDICAL SOCIETY OF NEW JERSEY
ANNUAL REPORTS TO THE HOUSE OF DELEGATES

May 21-23, 1946

PRESIDENT

Samuel Alexander, M.D., Park Ridge

This year has seen state medical activities change from those of a war period with all its implications to one of peace time and its problems of reconversion.

With the return of many of our members who served in the armed forces, let us not forget the sacrifices made by them. Their record is unique in the annals of warfare. Out of 4328 members, 1470 or 30 per cent served their country. All of these men were volunteers. No other professional or lay group whose members served in this war can begin to approach this record. The record made by these men is known to every one who served in the armed forces. We must continue to help our veterans to reëstablish themselves professionally and economically upon their return to civilian life.

The Welfare Committee under the able leadership of Dr. Sigurd W. Johnsen has had excellent meetings and much constructive work has been accomplished by it. The Legislative Committee has kept in close touch with legislation introduced in the Congress at Washington and in the State Legislature at Trenton. Largely due to the efforts of Dr. Frederic J. Quigley, secretary to the Committee, the officers and the members of the Welfare Committee have been kept informed of the type and progress of proposed legislation. The Public Relations Committee has instituted a definite program to secure and retain the good will of the people toward organized medicine in New Jersey. The Public Health Committee has been very active and its Cancer Committee has taken the leadership in conjunction with the New Jersey Cancer Society in the fight to awaken the people of our state to this serious problem. The Medical Practice Committee has had to deal largely with medico-economic problems which are being discussed more and more by interested non-professional groups, and activities of this nature cannot be underestimated.

The Committee on Graduate Education has finally consummated with Rutgers University a program for the establishment of a graduate course of study for general practitioners. A great deal of credit for this project must go to Dr. Decker and his committee members for the successful completion of this mission.

The New Jersey Health Congress proposed by the Welfare Committee is being organized under the leadership of our Society and will consist of representatives of the various professional groups, state government, agriculture, industry, labor and veterans. The purpose of this Congress is to consider and promote jointly all matters which affect the public health and medical care of the citizens of our state. It is hoped that much good will come from such a congress.

The Medical Service Administration has demonstrated its usefulness in the critical situation which arose when large numbers of veterans from the armed forces were rapidly demobilized. The medical care of veterans under federal legislation became a very acute problem. Government agencies found themselves unable to cope with this situation, and our State Society offered the services of its members to the Veterans Administration. As a result, a contract was signed with the Veterans Administration under which our members would coöperate in caring for these veterans. This project is to be administered by our Medical Service Administration. New Jersey was the fourth state in the Union and the first one in the east to sign such a contract. The medical care of the veteran is a challenge to organized medicine. The success or failure of this program may well determine the future status of medical care in this state and country.

Progress has been made with the Medical-Surgical Plan. More people are utilizing it and expansion should be very rapid in the near future. Much credit for the successful development of this plan is due to Dr. Norman M. Scott.

The Wagner-Murray-Dingell Bill is again before us and hearings are being held by a Senate Committee in Washington. I am confident that after all the facts relating to this problem are submitted, no legislative body will approve legislation which is so contrary to everything that has made this country what it is today.

I am not unmindful of the excellent work done by the Woman's Auxiliary and every en-

couragement must be given to these loyal workers to continue their work in our behalf.

The death of Dr. Andrew J. McBride of Paterson, N. J., was a shock to all who knew him. No doctor has rendered greater service to our Society than Dr. McBride, and his experience, wise counsel and advice will be sorely missed by those whose pleasure it was to serve with him. He represented all that was best in the doctor not only in his professional field, but as a citizen in his home community and state. To the credit of his city a lasting memorial is to be erected in his memory and the physicians of this state were given the privilege to contribute to this project.

Many professional and lay meetings have been attended by your president in various parts of the state and at these meetings the opinion and position of organized medicine was conveyed.

The permanent home of our Society in Trenton has been used by the various committees and Woman's Auxiliary to hold their meetings. It has been completely renovated and the prestige of our Society has been enhanced in the eyes of our members as well as in the eyes of those who have visited us.

I want to take this opportunity to thank the chairmen and members of the various committees who have given so much of their time, energy and ability in assisting me to carry on the work of the Society during the year.

My report would not be complete without publicly stating my appreciation to Mrs. Madden, Acting Executive Officer, and her office staff for the excellent work performed by them. They have been very coöperative and a great source of help to me in my work.

In closing, it is my conviction that well organized Public Relations and Legislative Bureaus are imperative if we are to maintain the position of organized medicine in this state. These projects are expensive but their cost is insignificant when compared with the potent dangers confronting medicine if our Society is not alert and active at all times. The price of non-preparedness with adequate Public Relation and Legislative Bureaus might well be the loss of private medical practice as we know it. With effective work in these fields and eternal vigilance, I am confident that The Medical Society of New Jersey will continue to meet the problems of modern community life with assurance and fortitude.

BOARD OF TRUSTEES

James F. Norton, M.D., Chairman, Jersey City

The Board of Trustees convened six times during the year: a reorganization meeting, one special meeting and four regular meetings. The activities of the Board have been reported in the *Journal* from time to time, and the minutes of the meetings have been published in various issues.

SECRETARY

Alfred Stahl, M.D., Newark

Statistical report on the Official List of Members of The Medical Society of New Jersey, as of March 1, 1945:

Paid-up Members, 1945	
Active	4,208
Associate	133
Members in Service, 1945	
Active	553
Associate	18
Members Deceased, March 1945-March 1946	40
Transfers, March 1945-March 1946	
In from Other States	12
Out to Other States	9
Within State	5
Resignations, March 1945--March 1946	2
New Members	96
Reinstated Members	22
Delinquencies (Members in 1945, not paid at time of Official List closing)	251

TREASURER

George J. Young, M.D., Morristown

The fiscal year of the Society does not close until May 31, 1946. A complete financial report will be presented directly to the House of Delegates.

JUDICIAL COUNCIL

Christopher C. Beling, M.D., Chairman, Newark

The Judicial Council has not had any matters referred to it for consideration during the past year.

FIRST DISTRICT

Essex, Morris, Union and Warren Counties

Christopher C. Beling, M.D., Councilor
Newark

No matters of a judicial or ethical nature were brought to the attention of the Councilor for the First District.

SECOND DISTRICT

Sussex, Bergen, Hudson and Passaic Counties

Vincent P. Butler, M.D., Councilor
Jersey City

As Councilor for the Second District, I wish to report that no matters requiring the consideration of the Council have been brought to my attention during the past year.

THIRD DISTRICT

Mercer, Middlesex, Somerset and Hunterdon Counties

Barclay S. Fuhrmann, M.D., Councilor
Flemington

Your Councilor for the Third District has nothing to report for the past year.

FOURTH DISTRICT

Camden, Burlington, Ocean and Monmouth Counties

S. Emlen Stokes, M.D., Councilor
Moorestown

Only one problem was reported to the Judicial Councilor for the Fourth District which called for action. This has now been settled. I assure the officers and members of each County Society in this district of my interest in their work and willingness to serve them whenever called upon.

FIFTH DISTRICT

Atlantic, Cape May, Cumberland, Gloucester and Salem Counties

Chester I. Ulmer, M.D., Councilor
Gibbstown

No matters of an ethical or judicial character were brought to the attention of the Councilor of this district during the year.

It would appear that the county societies in this district are functioning well and with harmony.

AMERICAN MEDICAL ASSOCIATION DELEGATES

Lucius F. Donohoe, Senior Attending Delegate, Bayonne

At the December meeting of the House of Delegates of the American Medical Association, the Senior Delegate from New Jersey was host at a dinner for Dr. Frank G. Scammell, Delegates and several friends. Following the dinner the New Jersey officers and delegates discussed the resolution to be presented at the next day's meeting of the House. Dr. Lewis was designated to read the resolution from New Jersey recommending establishment of a permanent working conference on medical care. Dr. Lewis also appeared before the Reference Committee to which it was referred and spoke on the resolution which was adopted. Highlight of the meeting was Major General Hawley's talk on the Veterans Administration.

STANDING COMMITTEES

FINANCE AND BUDGET

Harry R. North, M.D., Chairman, Trenton

The Committee on Finance and Budget has reviewed the expenditures for the current year, and the requested budget appropriations for 1945-46. A tentative budget for the new year has been set up, with the idea of curtailing expenditures as much as possible; certain recommendations will be presented to the Board of Trustees for consideration together with the proposed budget.

A meeting of the Committee will be held after the Trustees have reviewed the recommendations and proposed budget, at which time the final budget for 1946-47 will be prepared for presentation to the House of Delegates.

WOMAN'S AUXILIARY

William E. Dodd, M.D, Chairman, Beach Haven

The committee approved the annual program of the Woman's Auxiliary as submitted by its President, Mrs. William E. Dodd, as follows:

1. Promote public relations between The Medical Society of New Jersey and the laity, and to use the resources of the Woman's Auxiliary to acquaint the people of New Jersey with the efforts of organized medicine to provide adequate medical care at a price the people can afford to pay.

2. Give attention to controversial legislative matters and promote helpful legislation and oppose harmful legislation.

3. Coöperate in reëstablishment programs for members of the medical profession returning from military to civilian practice; and to be of aid to their families wherever possible.

4. Participate in maintaining the health of the people of New Jersey by the distribution of *Hygeia* and by health education.

5. Help in making the people of New Jersey "Safety Conscious", and thus aid in reducing accidents of all kinds.

6. Increase the circulation of the *Bulletin,* the national publication of the Woman's Auxiliary, in order to have a better informed working body.

7. Stress the benefits of the Society for the Relief of Widows and Orphans of the Medical Men of New Jersey.

8. Build a stronger, more united organization by increasing the membership of our Auxiliary.

From time to time during the year this Committee was called upon by the Woman's Auxiliary for advice in putting the above program into operation and it was happy to give as much assistance as it could.

The Advisory Committee met with a committee of the Woman's Auxiliary in charge of Revision of the By-Laws of that organization and approved the action of the committee on Revisions in which the By-Laws of the Woman's Auxiliary were proposed to be amended so that the duties of its officers would be more accurately defined. We recommended that, so far as was found to be practical, changes be made in the By-Laws to accomplish a minimum of confusion in executive matters passing through the central office of The Medical Society of New Jersey. We further recommended that the Committee of Revisions propose only such changes in the By-Laws as could be reasonably expected to serve the best interests of the Woman's Auxiliary and to promote harmony between the various component county Auxiliaries and the State organization. We further recommended that the committee on By-Laws and Revisions review the minutes of the Woman's Auxiliary and publish in booklet or mimeograph form the Constitution and By-Laws as they exist at the present time since the booklet now in use does not contain certain amendments and revisions which have been adopted and is therefore obviously out of date.

The Advisory Committee commends the efforts of the Woman's Auxiliary put forth during the year, and congratulates it upon its accomplishments.

PUBLICATION COMMITTEE

HENRY C. BARKHORN, M.D., Chairman, Newark

During 1945, *The Journal* printed 1124 pages, which represented the largest aggregate number of any year since 1941. At the end of the year, Dr. Davidson returned to the editorial position and assumed his duties with the issue of January, 1946. *The Journal* published 12 regular issues during 1945 and one supplement (the Official List of Members, supplement to the April issue). The usual practice of issuing a special *Transactions* supplement was suspended because no regular Annual Meeting had been held in 1945. The Committee's financial statement is presented below in table 1. An analysis of the distribution of *Journal* material by pages is exhibited in table 2. In addition to the regularly listed "State Activities," twenty pages were devoted to the listings of officers and committeemen in the advertising sections of the appropriate issues. Table 2 also indicates the distribution of material during each of the past five years. These figures are converted into percentages in table 3.

This year we will, surely, have more scientific material from our own members. We desire to publish all which is up to our standards and, therefore, we are asking for a moderate increase in our budget.

Following is a short financial statement and a table of distribution by pages:

TABLE 1

RECEIPTS

From June 1, 1945, to April 30, 1946

Net cash receipts	$21,080.18
Estimated receipts to May 31, 1946	3,170.22
Total	$24,250.40

EXPENSES

From June 1, 1945, to April 30, 1946

Journal	$15,619.94
Reprints	65.00
Estimated expenses to May 31, 1946	2,315.00
Total	$17,999.94

ADVERTISEMENTS

Included among the advertising pages are those devoted to *Society Organization,* as follows:

The index of the reading pages, which appears on the first cover page of each Journal	12 pages
The list of officers and committees	20 pages
Total	32 pages

SUPPLEMENT

April, 1945—Official List of Members .... 68 pages

TABLE 2

1945	Editorials	War News	Medical Service Administration	Medical-Surgical Plan	Original Articles	Executive Officer's Page	Legislative News	Timely Topics	State Activities	County Society Reports	Woman's Auxiliary	Bulletin Board	Book Reviews	Total Reading Pages	Pages of Advertising Including Covers	Total Pages in Monthly Issues
January	6				15				6	3	2		2	34	54	88
February	5				7				12	6	4		2	36	56	92
March	6				10				2	4	3		3	28	56	84
April	2				7				3	5	4		1	22	58	80
May	1								35					36	84	120
June	7				7				10	8	3		1	36	60	96
July	3								33	4	2		2	44	60	104
August	2				21				3	2	1		1	30	54	84
September	3			2	17				3		1		2	28	60	88
October	4				15				2		8		3	32	56	88
November	6				9				10	7	4		2	38	58	96
December	4				18				17	3	2		2	46	58	104
Totals 1945	49			2	126				136	42	34		21	410	714	1124
Totals 1944	41	4		8	164				142	31	29		23	442	586	1028
Totals 1943	29	26		19	244	2	12		157	19	21	4	26	476	484	960
Totals 1942	37	56			306	4	7	7	181	48	27	13	29	653	467	1120
Totals 1941	42				241				212	53	31	7	23	674	474	1148

TABLE 3

PERCENTAGES OF JOURNAL SPACE DEVOTED TO CERTAIN DEPARTMENTS

	Advertising	Original Articles	State Activities
1941	41	21	18
1942	41	27	16
1943	52	25	16
1944	57	16	13
1945	63	11	12

A five-year review of the distribution of *Journal* space discloses that the proportion devoted to original scientific articles fell from 21 per cent in 1941 to 11 per cent in 1945. This was accounted for by the increase in space assigned to advertising matter, which was 41 per cent in 1941 and 63 per cent last year, and also by the lack of original material because of the omission of the annual meeting and the absence of so many potential contributors. The relative amount of space allotted to State Society activities shows a decrease from 18 per cent in 1941 to 12 per cent in 1945.

The Committee is constantly aware of the need for a balanced intellectual diet and regrets the reduction of space devoted to scientific articles. Paper shortages, lack of submitted copy, and time pressures had made it impossible for us to retain the desired balance by publishing more scientific material, since if the latter were to keep pace with the augmented advertising copy, the result would be a magazine of unwieldy size, expensive production and delayed publication. Nor did it seem wise to curtail coverage of the Society's administrative activities. On the contrary, both increasing interest in health and hospital insurance and the progress of plans for the medical care of veterans call for added space in the "State Activities" section.

On the whole, 1945 was a successful year for *The Journal*. It was operated not only without expense to the Society but brought into the treasury a net of $6.000; which would have been $12,000 more if each member had actually been charged the $3.00 subscription fee. In those terms, *The Journal* would have shown a net return of $18,000, making it the Society's most valuable income producing property. *The Journal* measures its success, however, not in terms of money but in terms of service. We have served to link together the thousands of members in all parts of the state, to keep the profession informed of its Society's activities, to enter for the record the activities of the county societies and Woman's Auxiliary, to review the latest in medical books and to furnish our members with a state periodical for the reporting of interesting cases and publication of scientific papers.

The Committee's thanks are due to Dr. Norman M. Scott who has kept *The Journal* up-to-date in its publication of news of the Veterans plans and the Medical Service Administration and who, prior to Dr. Davidson's return from the Army, wrote most of the editorials; to Mrs. Madden of the Executive Offices; to Mr. Roy Hill of The Orange Publishing Company and to Mrs. Armstrong, the editorial secretary, who during the four-year absence of our editor shouldered so much of the burden of getting out *The Journal* every month.

MEDICAL DEFENSE AND INSURANCE

CHRISTOPHER C. BELING, M.D., Chairman, Newark

1. MEDICAL DEFENSE

During the past year approximately 2,775 doctors were insured under the special policy of the State Society. Exact figures on the loss ratio for the past year are not available. Analysis of the causes of suits cannot be made at this time because of lack of complete information. When we receive all the data we hope to submit a further report on this phase of the work.

Members are advised to obtain adequate limits of protection to meet the actions of litigious-minded patients because of the tendency for juries to give large verdicts. It is often the policy of an insurance company to settle within the insured's policy limits and we have had to keep in mind this need for increased protection because of the rise in the cost of damages for personal injuries or fatalities, arising from various causes; the doctor is not immune.

This is the fiftieth year of the existence of the United States Fidelity & Guaranty Company. For the latter half of this time it has served The Medical Society of New Jersey in safe-guarding our members against malpractice suits.

We take this opportunity of extending our felicitations to the Company and to hope that the cordial relations which have existed during the time will be prolonged indefinitely.

Physicians' defense insurance is a specialty and needs expert treatment to be made mutually successful and profitable. The time is opportune to allay the fears and unrest of the

doctors who feel that they are paying too much for the protection they are receiving. Members of the Committee have been receiving inquiries from doctors, and proposals from companies for better services and lower rates. Before acting on these "proposals" we recalled the recent experience of a Roentgen Society. They had a low rate given by an insurance company, which evidently thought the rate was sound. Now they have had to charge greatly increased rates and another company has stepped in and offered to write the insurance at rates well below that company's rates and somewhat below the rates of our company in a number of territories but well above the rates of the original company.

The matter comes up from time to time, but it has not escaped the attention of your Committee, which always considers the safety factor in the protection of members. We are giving it careful study.

A 20 per cent rise in rates was voluntarily assumed by the Society to offset the decreased income to the company as a result of the large number of doctors who entered military service. It was a question whether we were not due for an increase of rates according to the experience of the company. This matter too will be studied during the coming year.

Honorary Membership in the various County Societies was considered in relation to Medical Defense. It is a requirement that a member can obtain medical defense insurance only if he is in good standing in the State Society with his dues fully paid. If any active or regular member of a component Society is made an honorary member, while he does not pay dues to the County Society—the annual per capita assessment of the State Society has to be paid before he can be in good standing in the State Society and thereby qualify for medical defense insurance.

2. ACCIDENT AND HEALTH INSURANCE

During the past year, more than half the members of the State Society subscribed to the Group Plan of Accident and Health Insurance underwritten by National Casualty Company, thus making each policy individually non-cancellable on a group basis. This was accomplished during the past two years when each county society was given an enrollment period by the Insurance Company and each doctor under the age of 65 years had the opportunity of joining the group program, regardless of physical impairment or past medical or insurance history.

More than 50 per cent of the members of the component county societies enrolled and thus brought about completion of the program, which was outlined several years ago and set forth in the 1943 report of your committee on Medical Defense and Insurance.

Your committee wishes to express its appreciation to the county societies for their cooperation. Particularly the County Societies of Bergen, Passaic and Union, which were the first to put through the program.

New members and those returning from military service are being given a 60-day period, during which they may join the group insurance program on a non-selective basis, regardless of physical impairment or past medical or insurance history.

The rate of our accident and health policy is 30 to 40 per cent lower than the cost of similar policies purchasable on a retail or individual basis in the open market. It may further be noted that while such other policies are cancellable, our State Society policy is individually non-cancellable as long as the group plan is in existence and so long as the doctor practices medicine and remains a member of the Medical Society in good standing, and pays his premium when due under these terms. There is no terminal age limit for renewal.

It may be mentioned here that the age limit for acceptance of risks by the Insurance Company is the sixty-fifth birthday.

The members of the Societies who have not as yet taken advantage of subscribing to the policy may yet be included in the program on the basis of an acceptable application approved by the company.

Your committee has worked hard for many years to reach the goal of having a non-cancellable group plan of accident and health insurance, now one of the leading plans of its kind in the country. This plan has been studied and accepted by other societies in the country—e. g. New Jersey State Dental Society, The Dental Society of the State of New York, the Medical Society of the County of New York, The Bronx and Westchester County Medical Societies, The Hartford and New Haven County Bar Associations and in California by The Los Angeles County Medical Association and the Southern California State Dental Association.

The Committee wishes to thank the Secretaries and the Chairmen of the Insurance Committees of the component societies for their continued coöperation in furnishing our brokers, Messrs. E. & W. Blanksteen, with monthly lists of new members and of old members returning from military service so that they could be promptly informed of their 60-day privilege of joining the group on a non-selective basis.

The Committee lost one of its members by death. Dr. Charles J. Larkey of Bayonne died

on February 18, 1946. In addition to numerous professional and other activities, he always found time to be of help to the Committee, especially on critical occasions. We shall miss him in our deliberations.

RECOMMENDATIONS

A. *Medical Defense Insurance:* (a) Renewal of the Special Policy of the U. S. Fidelity and Guaranty Company. (b) Congratulations to the Company on its fiftieth anniversary. (c) The continuation of Messrs. Faulhaber & Heard as our official brokers.

B. *Accident and Health Insurance:* The continuation of Messrs. E. & W. Blanksteen as our accident and health insurance representatives during the coming year.

ANNUAL MEETING

Harrold A. Murray, M.D., Chairman, Newark

The 1946 Annual Meeting will be held again at the Claridge Hotel, Atlantic City. Because of limited space, scientific and educational exhibits have been eliminated from the meeting, but a number of technical exhibits will be shown.

Schedule for the meeting follows the same lines as in previous years. President Alexander has arranged the general sessions on Tuesday and Thursday and section officers have planned the scientific programs on Wednesday.

It is regrettable that we are limited this year as to exhibit space and hotel rooms. Requests for hotel reservations have been overwhelming and we expect this year's attendance to be larger than ever before. Preliminary schedule of the meeting was mailed to all members of the Society in February and an advance announcement of the program will be mailed to the membership on May first. The May *Journal* will carry the final program and annual reports of the committees together with a brief description of all exhibits.

As in previous years, receipts from the technical exhibits will pay all costs of the Annual Meeting and will undoubtedly net a profit to the State Society.

The Committee feels that an excellent meeting has been planned for the benefit of the Society members and urges all who can get away for a day or more to go to Atlantic City and participate in the fine programs and social events arranged for your enjoyment.

SCIENTIFIC PROGRAM

Thomas McG. Brennock, M.D., Chairman, Jersey City

Scientific Program of the 1946 Annual Meeting has been prepared with great care. Section Officers have been most coöperative and deserve a great deal of credit for the excellent papers to be delivered at the Section Meetings on the second day of our Convention.

The Society is grateful to the speakers who have so willingly accepted our invitation to speak and contribute to the greater success of our meeting.

SCIENTIFIC WORK

William Wallace Maver, M.D., Chairman, Jersey City

With the conclusion of the war it becomes possible to review and in some degree evaluate some of the subjects of scientific interest which may be of far-reaching importance in the future practice of medicine.

The end of this fiscal year marks the development of the harnessing and storing of "blocks" of atomic energy which will probably prove of startling significance in the application of radiant energy to the treatment of disease.

The evaluation of the older agents and the development of the newer agents in chemotherapy is progressing with encouraging results in the many fields of infectious diseases.

Research in cancer continues and the reports from men who are pursuing investigations with enzymes, inhibitory agents and anti-virus derivatives lead us to hope that in the not too distant future a means of combating cancer in its varied manifestations and stages will be available to the profession.

In our own state, investigation of the agent known as anti-reticular cytotoxic serum—A.C.S. is continuing and the effect of this agent upon the connective tissue of the body in Hodgkins disease, carcinoma and senile changes is being pursued.

The 50th anniversary of the discovery of x-rays was commemorated November 8, 1945. As a result of the use of x-rays in Induction Centers, has come a more complete realization that this type of chest examination may soon become a routine hospital procedure. Mass surveys, under proper medical supervision, are expected to reduce the incidence of tuberculosis as well as give information relative to other unsuspected lesions in the general population.

The war has also served as a stimulating medium for a bolder surgical approach to thoracic lesions, and lobectomy, pneumonectomy and decortication procedures give promise of brilliant results in specially trained hands. The same applies to surgery of the heart and the blood vessels.

The use of the amino acids in starvation and other debilitated states is, and will probably continue to be an accepted practice.

These are a few of the most outstanding items of scientific interest to medical men. Undoubtedly other equally important developments could be mentioned and it is probable that in our Society credit should be given to individuals who are delving into difficult scientific problems.

The Scientific Work Committee is largely dependent upon the reporters of the various County Societies for such information relative to the individual State Society members, and it is hoped that in the future a closer liaison may be established between these reporter groups and the members of the Scientific Work Committee.

POST-GRADUATE EDUCATION

HENRY B. DECKER, M.D., Chairman, Camden

A detailed report on the project of post-graduate education for general practitioners, which the Society has evolved with Rutgers University, will be presented orally to the House of Delegates in May. The Board of Trustees have been apprised of our progress.

WELFARE

SIGURD W. JOHNSEN, M.D., Chairman, Passaic

The Welfare Committee met June 10, 1945; October 7, 1945; January 13, 1946, and March 31, 1946. Each meeting was well attended and representatives from every County Medical Society participated. The actions of the Welfare Committee and its sub-committees have been reported in detail in the *Journal* and need not be repeated at this time.

The Welfare Committee has functioned as a democratic body and represents all our County Medical Societies. Actions of the Welfare Committee have, in this manner, been communicated directly to all the coöperating county societies and this is a valuable and effective working organization.

I wish to express, as Chairman, my sincere thanks and appreciation to every one on the committee for giving up so much valuable time to the work of our State Medical Society. To our President, Dr. Samuel Alexander, who has directed our work and coördinated our efforts, we owe a special debt of gratitude.

The Board of Trustees has coöperated wholeheartedly in our work. The innovation introduced this year, of inviting the chairman of the Welfare Committee and other chairmen of sub-committees, to report directly to the Board, has been greatly appreciated. This has resulted in a better coöperative effort in carrying through policies and consummating action on proposals which might otherwise be lost sight of in the mass of work the Board is called on to do. I believe this practice should be continued.

The work of The Medical Society of New Jersey, carried on through the organizational setup of the Welfare Committee with its sub-committees and advisory committees, supported by its Board of Trustees, and backed by its County Medical Societies, has made New Jersey one of the foremost leaders of Organized Medicine. We are far ahead of most states in our medical leadership. This is due to the harmony and coöperative spirit which

has prevailed in our work. We have a democratic organization which depends on the backing of every one of our component County Medical Societies. The work is carried out by self-sacrificing members who think more of what they are doing for Organized Medicine than what they get out of it for themselves. So long as this self-sacrificing coöperative spirit prevails, the work of The Medical Society of New Jersey will continue to prosper.

SUBCOMMITTEES

LEGISLATION

B. S. Pollak, M.D., Chairman, Jersey City

More frequently than not we have been obliged to write a report of the activities of this Committee in the midst of the State Legislative Session, making its compilation at that time quite unsatisfactory.

Because of the introduction of several important bills in which we have special interest, none of which has been disposed of as yet, and because the national legislative picture on health matters is not at all clear at the moment, it has been decided this year to make the supplementary report the real report of the Committee. By the time the supplementary report is to be delivered we feel quite certain that we shall be able to make a report which has real meaning.

PUBLIC RELATIONS

L. Samuel Sica, M.D., Chairman, Trenton

The Public Relations Committee has a threefold mission. First, to channel health education to the public; second, to present to the community the attitude of organized medicine on problems of medical economics; and third, an institutional function to present in a favorable light the medical profession in general. This report will examine the activities of the Committee under all three headings.

HEALTH EDUCATION

1. Interest in health education has waned considerably during the last few years. Before the war, the Committee had a more or less continual stream of inquiries on health matters and requests for speakers on health topics. During the current year not a single request for a speaker on any scientific topic has come to the committee. However, the committee has discharged its health education function through two media. One has been the weekly radio broadcast transmitted over each of four New Jersey stations every Sunday. The material is electrically transcribed and is taken from records furnished to us gratis by the American Medical Association. This aspect of our work has been conducted without expense to the Society since radio time is furnished by the stations without charge. The second medium has been the press. Major activity here has been the weekly newspaper releases usually printed under the caption *Health Hints,* sometimes called *The Doctor Says* or *Timely Medical Topics,* according to the preference of the individual editor. These have been the chief drain on the budget of the Committee since it has been found necessary to send the releases in the form of mats so that small town editors could print directly from the mats without using their own type. Up to March 18th this cost us about $100.00 a week. The mats and proof cost $88.95 a week and the mailing through the New Jersey Press Association represents a weekly expenditure of $11.50. Starting March 18th, however, the Committee has arranged through a Philadelphia organization to have the same job done for about $66.00 a week, a saving of one third. Part of the saving is effected by our furnishing the printer with the mailing list instead of using the facilities of the New Jersey Press Association as in the past. The *Health Hints* series concerns itself with scientific topics of public interest written in such a manner as to hold the attention of the lay reader. We polled the papers and received only twenty-one answers indicating that the column was not being used. Most of the other newspaper editors replied that they were using *Health Hints* and wanted them continued. On the basis of these responses it is felt that the

column has justified itself. Further evidence of the readership of the column and of the audience for the radio broadcasts is furnished by the occasional but steady stream of requests for copies which we receive from the lay public.

HEALTH INSURANCE

2. Our second mission was to publicize the attitude of organized medicine on health insurance projects and to furnish the laity with our reasons for the attitude. This has been a difficult task. All questions on the distribution of medical care have now crystalized around the Wagner-Murray-Dingell bill, the attitude towards which is generally accepted as a touchstone of feeling on the subject. Since this is a national bill it required, of course, a national approach and there were decided limitations on what could be done at state level. Another difficulty was that the Society was not in a position to furnish speakers to go out and address lay audiences on the subject. It was found that only three or four doctors in the state were willing and able to handle these assignments. Few doctors could or would take the time necessary to go to luncheon and evening meetings and present our point of view and surprisingly few physicians are sufficiently well-documented to handle skillfully the many questions thrown at them in those meetings. Your Committee believes strongly that speakers should come at the county level. It is easier for a doctor to go to a meeting in his own county than for one to have to travel to the other end of the state. The doctor who is known to the community is more favorably received than one from another part of the state, particularly if the latter is an employee of The Medical Society rather than a private practitioner. Although this was our conviction, the counties were hardly ever able to furnish a speaker on an economic or administrative topic. On the contrary, most county societies forwarded these requests to Trenton; when your Committee asked a county society to send out a speaker in its own area there was scant response. Another factor which has hindered our program has been our observation that many of the organizations most interested in this topic were already committed to compulsory health insurance and asked The Medical Society to furnish speakers chiefly for the purpose of picking flaws in their argument. It was the uniform experience of doctors who spoke to such organizations that the audience had come to the meeting with opinions already crystalized against the attitude of Organized Medicine.

On the positive side of the ledger it is to be noted that Dr. Scott spoke to about thirty groups during fall and winter season on such matters and that Dr. Quigley acted as Society spokesman on many other occasions. We have also accumulated in the Trenton office a supply of printed and mimeographed material which presents Organized Medicine's point of view and which we have sent to meetings where it would do the most good. For example: we were asked by the A. M. A. to send some indoctrination material to the delegates to the National Y. W. C. A. Convention in Atlantic City in March. Although this was national and not a local matter, the A. M. A. felt that the N. J. Committee should handle this because we were the host state. Such material was sent to the key delegates to the Convention. Packages of approved pamphlets on economic matters have been sent out to about a dozen individual or organizational lay inquirers.

FAVORABLE PUBLIC RELATIONS

3. On the institutional level the Committee has handled numerous letters sent to it from various lay sources. For example: we have received inquiries from school teachers as to the economic stand of Organized Medicine or requests for scientific material. These were to be used in class room discussions. Such requests have been promptly and, we think, adequately fulfilled. We have worked closely with the Woman's Auxiliary on a number of projects in Public Relations and put on record here a tribute to their coöperation and effectiveness. The Public Relations Committee has also been asked to organize a State Health Congress to implement the recommendation of the A. M. A. and we have taken the leadership in setting up such a Congress. More details on the State Health Congress will be furnished in an interim report.

During the year, your Chairman attended three special meetings of Public Relations interest. One was a national welfare committee conference in Chicago last October, one was a regional welfare conference in Philadelphia this February and the third was a joint meeting with leaders of the American Legion in Newark in January.

With the development of the Veterans Care Plan, it became impossible for Dr. Scott to devote more time to public relations work since he was already busy with Medical Service Administration and Medical-Surgical Plan. Accordingly, Dr. Scott was relieved of this burden in January and the editor of our *Journal*, Dr. Davidson, who had been our Public Relations Officer before the war, was retained as Executive Secretary to the Committee.

RECOMMENDATIONS

Our most pressing need is the establishment of a bureau of doctors willing to speak on economic topics. Because we have no such agency, we have often been obliged to abandon the public discussion field entirely to proponents of compulsory health insurance, who are usually quite articulate. Organizations have no difficulty in obtaining orators in favor of sickness insurance, whereas we have been quite unable to fill their requests for speakers to present the point of view of Organized Medicine. The three or four doctors available now for that work cannot be asked to cover the entire state. For reasons already indicated, these speakers must be obtained from county sources. The State Society will operate a central clearing house for requests, will forward printed matter, prepare question-and-answer data for the use of speakers, and if requested, will even furnish complete talks. It is recommended that each county society prepare a list of members willing to talk on economic problems, and forward such a list to the State Public Relations Office. We need at least one doctor in each county, and in the larger counties, we need one speaker to about every 75 members. Thus, a county society with a membership of 300, should be able to furnish four speakers. Once these names are on file, the State Office will have an alert Speakers' Bureau able to fulfill our commitments in the field of public education. This is our only pressing need and our own only recommendation at this time. The Committee asks for no additional funds. We shall continue to present health and economic information through the press and radio and by the sending out of pamphlets and printed matter. But under the American way of open debate and in the American tradition of the Town-Meeting type of discussion, there is, in the last analysis, no substitute for the personal persuasiveness of the human voice. That the doctor himself is medicine's best public relations agent is a truism. We can put life in that truism, however, only if we can rely on the active participation of physicians from every part of the state.

I cannot conclude this report without expressing my appreciation of the energy and efficiency of the clerical staff in the State Society office who were so helpful in the preparation of copy and handling of correspondence; and I must also put on my record my thanks to Dr. Scott, Dr. Quigley and Dr. Davidson for their many labors on behalf of public relations and for their helpful advice and counsel.

PUBLIC HEALTH

Stanley Nichols, M.D., Chairman, Long Branch

Under the constantly changing conditions of a transition year from war to peace, our Public Health Committee and Advisory Committees have carried out our essential objective of maintaining the best possible public health and medical care services for all residents of New Jersey in close collaboration with the Health and Welfare Agencies of this State. With the sole exception of venereal diseases, wartime disease increases have largely failed to materialize and the physical health of the public and the nation has been excellent. Whether the same can be said of the *mental* health of the public, the nation, and the world is a moot question, which we leave to our Mental Hygiene Committee.

Our Advisory Committees have handled all essential health problems referred to them in a constructive way and will submit their own brief reports. These Committees are entitled to the sincere thanks of this Society.

THE COMMITTEE YEAR

Under the wartime handicaps present in May, 1945, all Advisory Committees, except the following three, were requested to meet and act only when urgent health matters in their field required attention. Three Committees had immediate and important health problems and have done excellent work.

1. CANCER CONTROL

Dr. Keir and his Committee have done a splendid job in connection with the expanding State Program of the New Jersey Division of the American Cancer Society.

2. TROPICAL DISEASES

Dr. Segard and Committee, in conjunction with the State Department of Health, are rendering special service in connection with the still existing possibilities of tropical disease developments in the State, particularly malaria.

3. MENTAL HYGIENE

The Mental Hygiene Committee has been laying the groundwork for good psychiatric education of physicians, as an essential in good medical practice as well as in the mental problems of veterans.

There are three general problems which have a direct bearing on the Public Health Committee's work.

1. REORGANIZATION OF THE STATE DEPARTMENT OF HEALTH

Our Committee has assisted the Legislative Committee in a study of a reorganization bill, now before the Legislature. It is of great importance to public health that this Bill be so constructed as to improve the public health cooperation in this State among the (1) health professions, (2) the State Health Department, and (3) the public to be served.

2. THE WAGNER-MURRAY-DINGELL BILL, THE PEPPER BILL, AND THE HILL-BURTON BILL

These national bills contain the greatest potentialities for good and ill in public health matters of any proposed legislation in this decade. Our Committee, at the request of the Legislative Committee, prepared a statement of beliefs of our members and physicians generally, as to *governmental medicine,* its good or bad effects on public health, and the quality of medical care, and how these might be safeguarded by a real working coöperation between governmental and medical agencies. This statement of beliefs was adopted by the Welfare Committee and Board of Trustees and presented by our delegates to the House of Delegates of the American Medical Association at its Chicago meeting in December. This resolution, in conjunction with one covering a wider field from the Illinois Medical Society, was referred to the Council on Medical Service and Public Relations, who are now setting up a National Voluntary Health Congress of (1) the health professions, (2) governmental agencies, and (3) public consumer groups (particularly labor, industry, and farm organizations), to study and promote *voluntary health* insurance as a good method of meeting public health medical needs.

The Wagner and Pepper Bills represent legislative *compulsory* methods directed toward these same ends. This is the most outstanding public health and medical care problem confronting our members and the medical profession generally, namely, whether *voluntary* cooperative methods, such as voluntary prepayment plans, or laws with their *compulsions* (whether they be compulsory health insurance or by general taxation), shall be the method of procedure to provide good public health medical care for all people.

Our Committee strongly urges every member of the State Society to study this matter carefully as it directly affects the *quality* of medical care which he will be able to render to his patients in the future.

Following the definite recommendation of the American Medical Association, the Committee proposed and the Welfare Committee and Board of Trustees approved, that the State Society's Public Relations Committee set up a State Health Congress for the regular discussion and promotion of better health and medical care for all persons in New Jersey. This development, properly supported by our members, together with the Veterans Medical Care Plan, and the expansion of our State Medical-Surgical Plan and Medical Service Administration under our able Dr. Scott and his hard-working Boards of Directors, will go a long way toward demonstrating concretely to the public generally that The Medical Society of New Jersey is doing its utmost to provide the best possible public health and medical care to all citizens of this state.

An additional annual health forum for similar health discussions will be provided if the New Jersey Health and Sanitary Association changes its Constitution, at its Annual Meeting in March, to include official representatives of the five New Jersey health professions (doctors, dentists, nurses, pharmacists and hospitals) on the General Council as has been proposed.

3. PUBLIC RELATIONS IN THE STATE

In the past, our Committee, with its consultants and technical advisers, and our Advisory Committees have through the years established good working relationships with Health and Welfare Agencies in the State. This year the efficiency of this public health relations work, which has been growing steadily, has been immensely enhanced by the excellent work and program of the Public Relations Committee under Dr. Sica, and the recent addition of Dr. Davidson's services as part-time Executive Secretary of the Committee. If our Society will wisely expend increasing funds on this public relations program and provide it with additional trained staff personnel, it will go a long way toward insuring our members against revolutionary governmental, social welfare, or political public health medical care and will assure the same orderly evolution which has been developing during the past 15 years in these increasingly overlapping medical fields.

An interesting request for assistance from

the New Jersey State Commission on Temperance and Alcohol Control and the Department of Sociology of Rutgers University, as to the alcohol problem, was referred to the Public Health Committee. It is most encouraging that a state which derives income from taxation on liquor wished to find out if possible what can be learned about lessening the bad results of alcoholism.

Believing that alcoholism is to a large extent a psychiatric disorder, our excellent Mental Hygiene Committee is aiding Rutgers University in this study.

RECOMMENDATIONS FOR THE COMING YEAR

1. PUBLIC HEALTH COMMITTEE

It is recommended that the present Committee on Tuberculosis and Adult Disease Control be redivided into four Advisory Committees: (1) Tuberculosis Control, (2) Cardiovascular Disease Control, (3) Nutrition, and (4) Adult Health Supervision.

2. PERSONNEL

In view of the above report of public health medical care problems facing the medical profession, and in view of the rapid expansion of lay public health movements with large funds (such as the 1945 $16,000,000.00 Infantile Paralysis Fund, the $4,000,000.00 American Cancer Society Fund, and many others) which need much professional medical coöperation and guidance, it is strongly recommended that the Executive Secretary of the Public Relations Committee be also engaged to serve as Executive Secretary of the Public Health Committee with additional compensation therefor.

3. MEDICAL SOCIETY ADMINISTRATIVE STAFFS

In order that the public health practice and private practice of medicine of New Jersey's physicians shall continue to meet public needs by orderly evolution, it is recommended that some plan be devised by the State Officers and Executive Staff which will make it possible for each county society to have a business office with fulltime or parttime executive secretaries, so that our busy member physicians shall be properly and continually represented in the complicated and numerous public health, veterans medical care, and medical service developments that confront the practicing physician today in increasing volume.

Allow us to urge that all members of The Medical Society of New Jersey give serious thought to all of these problems during this coming crucial year, so that organized medicine in this state shall continue by orderly evolution to meet public needs by combining public health practice with private practice in the public interest.

MEDICAL PRACTICE

HARRISON B. WILSON, M.D., Chairman, Hackensack

The Subcommittee on Medical Practice has held four sessions during the year. The recommendations of these meetings have been published in the *Journal*. The annual reports of the Advisory Committees give a comprehensive picture of the work of the Subcommittees.

ACADEMY OF MEDICINE, ANNUAL MEETING

Announcement is made of the Annual Meeting of the Academy of Medicine on Thursday, May 16, at 8:45 p. m. at the Academy's Building, 91 Lincoln Park, Newark. This session will be occasion for the presentation of the *Edward J. Ill Award* to CHARLES H. SCHLICHTER, M.D. Citation and presentation will be by DR. EARL LEROY WOOD with response by Dr. Schlichter. Essayist of the evening, J. B. RICE, M.D., Director of Medical Research of Winthrop Chemical Co., will talk on "Newer Knowledge in Malaria".

ADVISORY COMMITTEES
PUBLIC HEALTH

CANCER CONTROL

Floyd E. Keir, M.D., Chairman, Englewood

The Cancer Committee has been confronted with many demands during the past year, which has been one of the most important in the committee's history.

AMERICAN CANCER SOCIETY

Influential, civic-minded laymen entered into the cancer program and demanded a joint responsibility with medical groups in meeting the problem. The lay groups were particularly interested in the collection of funds, organizational work, education and research.

The objective of the Committee was to effect a healthy integration of The Medical Society, the Board of Health, the Department of Institutions and Agencies, and the new American Cancer Society. We feel that an ideal working relationship has been brought about through physician representation from the county levels. According to plan, one physician and one layman are appointed by each county chapter to the Board of Directors of the American Cancer Society, New Jersey State Division. It is the policy that the chairman of the state executive committee and the chairman of the local county executive committee be physicians.

Of the funds collected in 1945, 50 per cent were allocated to the national organization and 50 per cent remained in the state. All county projects requiring funds from the American Cancer Society must be approved by the local county medical society.

Another aim of the Committee is to place medical leadership in the hands of medical men who treat cancer, reaffirming a previous recommendation made on November 26, 1944, to the effect that: *"the association of tumor clinics be the guiding force in the development of cancer control work in the State of New Jersey and that the key man in any successful cancer control program be the family physician."* The Committee feels that any program of cancer control that does not properly incorporate the activities of the family physician is bound to fail.

SURVEY OF FACILITIES

Another step in team work has been the survey of facilities for the care and treatment of cancer in New Jersey. This project is a joint effort on the part of The Medical Society of New Jersey, the American Cancer Society (furnishing twenty thousand dollars), the Department of Health and the Department of Institutions and Agencies. The director of the survey is Dr. L. S. Snegeriff. Dr. Emil Frankel of the Department of Institutions and Agencies will conduct a statistical research as a part of this project.

PROPOSED STATE HOSPITAL

A special meeting of the Advisory Cancer Committee on January 13, 1946, discussed with Commissioner Bates the proposal of the Morristown Board of Freeholders for a state cancer hospital. It was the consensus that the care and treatment of the cancer patient be considered a part of the problem of the care of the allied chronic diseases and that the program be developed on a county level. The committee felt that no action should be considered until all facts could be obtained which would disclose the facilities for the care and treatment of cancer in New Jersey. Such a survey is now in progress under joint supervision of The Medical Society of New Jersey, the Department of Institutions and Agencies, the American Cancer Society and the State Department of Health. Funds are provided by the N. J. Division of the American Cancer Society supplemented by the labors of the various state departments coöperating in this worth-while survey.

THE SHERSHIN BILL

On February 11, 1946, Mr. Shershin of Passaic County introduced into the legislature a bill designated Assembly No. 171, full text of which follows:

1. There is hereby created a "Bureau of Cancer Control" which shall be a division under the State Department of Health.

2. The bureau shall be under the supervision of a director, who shall be a duly licensed medical physician in this State and qualified by training and experience to direct the work of cancer control, and be competent to administer cancer clinics. The director shall devote his entire time and attention to the performance of his duties and shall be paid such compensation as shall be fixed by the State Board of Health.

3. The Bureau of Cancer Control shall make a study concerning cancer insofar as this disease relates to the public health and welfare of the citizens of this State; shall make provisions for ade-

quate cancer research; and, shall, from time to time, make such recommendations to the State Board of Health or to the public health council, as may be consistent for the best interests of the State in controlling the spread of cancer.

4. There shall be established within the State four cancer clinics which shall be under the direct supervision and operation of the Bureau of Cancer Control. Two such clinics shall be established in the northern part of the State; one in the central part of the State; and one in the southern section of the State. Only duly licensed medical physicians shall be in charge of any such clinic so established by the Bureau of Cancer Control. The location of said clinics shall be determined by the State Board of Health or public health council upon the recommendation of the Bureau of Cancer Control.

5. There is appropriated to the State Board of Health or public health council, the sum of $250,000, when included in any annual appropriation act, dedicated exclusively for use of said Bureau of Cancer Control. The appropriation hereby provided for shall be in addition to such appropriations as shall be made from time to time for the general expenses of said Bureau of Cancer Control.

No meeting of the Committee has been called for consideration of this bill since it was felt that it would be better to wait until the survey had been completed.

CHILD HEALTH

Harrold A. Murray, M.D., Chairman, Newark

As in previous years, the Child Health Committee has endeavored to meet problems which concern the health of children in our state. To help accomplish this objective, we have joined our efforts with those of the Fellows of the American Academy of Pediatrics in New Jersey.

We have secured the services of a full-time pediatrician to direct the Rheumatic Fever Program in the state. He is well qualified and arrangements are under way to install a demonstration unit at one of the hospitals in Newark. This will be of invaluable aid in prevention and control of this disease, which handicaps so many of our children each year.

Permission has been given by the Board of Trustees of our Society to coöperate with the National Survey being conducted by the American Academy of Pediatrics on Child Health Services in the country. Through the generosity of the Roche Anniversary Fund, we have been assured financial help in this worthy study. Headquarters for the Survey will be at the Babies Hospital-Coit Memorial in Newark, whose Board of Trustees have donated office space. The Bureau of Maternal and Child Health as usual has promised to be of invaluable assistance, and each physician, agency and hospital in the state interested in the care of children will be asked to fill out a questionnaire, the information from which will determine the availability of child care services in New Jersey.

We have sent suggestions for the control and prevention of infectious diarrhea of the newborn to each hospital. We have established a consulting service, consisting of qualified physicians, who will assist any hospital confronted with this fatal disease.

We have entered into public discussions with the proponents of the various bills now before Congress, which would tend to interfere with the excellent child care programs already so well established in our state.

We recognize the great need for clinics for the troubled parent whose child is a behavior problem. Since this is so prevalent and at such an early age, it will be our effort to meet this need quickly by establishing clinics where proper advice and therapy can be given by qualified physicians.

CONSERVATION OF VISION AND HEARING

Elbert S. Sherman, M.D., Chairman, Newark

The Committee had only one meeting. This was for the purpose of discussing a request by the New Jersey State Commission for the Blind for advice on a proposed mobile eye clinic. This clinic, first of its type in the country, is mounted on a truck or trailer, and under direction of an ophthalmologist, brings facilities for examination and diagnosis of eye conditions to the more remote rural areas of the State. This is done in coöperation with school authorities, county welfare boards and other social agencies. It is a project of the Junior Women's Clubs, who have volunteered to purchase and maintain the outfit for one year.

The clinic is to be operated by the Commission as a part of its service for the conservation of vision and prevention of blindness.

Our Committee approved the proposal.

CRIPPLED CHILDREN

H. EUGENE READING, M.D., Chairman, Paterson

One of the important topics during the past year was the Wagner-Murray-Dingell Bill, as it relates to crippled children. The Crippled Children's Commission for the State of New Jersey has for a number of years fulfilled its obligations in providing hospital and convalescent care for the indigent crippled child with a congenital or acquired deformity, or suffering from the early effects of poliomyelitis. It is possible that the Crippled Children's Commission may in the very near future expand its program so as to supplant any proposed federal plan which might be administered by the Surgeon General's Office in the U. S. Public Health Service.

A project is in the planning stage to build and equip a 130-bed hospital in Passaic County, with county funds, for the treatment of crippled children and those suffering from rheumatic heart disease. This portrays the desire of a community to assume the responsibility for specialized medical and surgical care that might otherwise be controlled by federal legislation such as Senate Bill 1050 proposes.

Special meetings of the Crippled Children's Committee were not held, since no urgent problems arose during the past few months.

MATERNAL WELFARE

WALTER B. MOUNT, M.D., Chairman, Montclair

The Field Physicians have continued to do their work excellently, in spite of handicaps affecting all in the war years. A gratifying number of hospitals have compiled and forwarded yearly reports of obstetric work. Statistics from these reports have always been slightly incomplete and inaccurate and are not printed in detail. The maternal mortality rate (16 per 10,000 live births) for 1945 is the same as in 1944. This is noteworthy in view of and in spite of the added pressure of work by civilian physicians because of war conditions. At least in part it must be attributed to increased appreciation by the patients and physicians of what constitutes good antepartum and maternal care, due to years of guided publicity.

Return of physicians from the services has already eased the burden of individual work and still better obstetrics may be hoped for. However, little further reduction in maternal mortality rates may be expected. Probably new or other methods of attacks on the problem will have to be devised, and what they should be is at the moment not clear. The returned medical officers are serious and determined to better their knowledge and are inclined to be worthy of certification by one of the American Boards and to practice specialties. This seems like a hopeful attitude. And still not all obstetrics can be done by specialists.

Hemorrhage is still causing too many deaths and should be better guarded against.

TABLE NO. 1

1945 MATERNAL MORTALITY STATISTICS

Causes of Death	Total	Time of Death in Relation to Delivery: Ectopic Gestation	During or After Abortion	Before Delivery	During or After Childbirth
All causes	122	10	23	10	79
Infections	31	2	10	.	19
Toxemias	27	.	4	5	18
Hemorrhage, trauma, shock	52	8	2	1	41
Other and unspecified causes	12	..	7	4	1

1945 Maternal Mortality Rate—16 per 10,000 live births.

TABLE NO. 2

Distribution of Maternal Deaths by Time of Death in Relation to Delivery in Each County by Place of Residence

Number of Births — 1945	Total Deaths	Abortion	Ectopic Gestation	Before Delivery	During or After Childbirth
New Jersey (76,995)	122	23	10	10	79
County					
Atlantic (2,039)	3	1	..	..	2
Bergen (7,930)	5	1	..	..	4
Burlington (1,860)	1	..	..	..	1
Camden (5,066)	11	2	2	..	7
Cape May (543)	1	..	..	..	1
Cumberland (1,463)	6	2	..	1	3
Essex (15,404)	27	4	4	..	19
Gloucester (1,444)	3	..	..	1	2
Hudson (10,858)	13	3	..	1	9
Hunterdon (528)	..	..	..	..	..
Mercer (3,678)	7	1	1	2	3
Middlesex (4,011)	5	..	..	1	4
Monmouth (3,338)	5	1	..	..	4
Morris (2,372)	5	1	..	1	3
Ocean (751)	2	..	..	1	1
Passaic (5,203)	10	3	..	1	6
Salem (970)	2	..	..	1	1
Somerset (1,505)	2	..	..	..	2
Sussex (585)	2	1	..	..	1
Union (6,623)	8	1	3	..	4
Warren (824)	2	..	..	..	2
Out-of-State	2	2	..	..	..

MENTAL HYGIENE

Arthur P. Hasking, M.D., Jersey City

Your Mental Hygiene Committee has worked closely with the corresponding committee of the State Department of Institutions and Agencies. We have the following recommendations: (1) Psychiatric services in general hospitals, (2) use of mental hospital facilities for the training of the medical as well as the nursing staffs of general hospitals, (3) enlargement of existing institutions for the psychotic, defective and epileptic, (4) coöperation with Rutgers University in its current survey of alcoholism, (5) expansion of mental hygiene clinic facilities. The State Department of Institutions and Agencies has just released a report on this subject, which we fully endorse. This report proposes the following:

(a) A staff of a mental hygiene clinic should consist basically of one psychiatrist, one psychologist, two psychiatric social workers and two clerks. The Committee does not think it advisable for the psychiatrist in the clinic to sign commitment papers since it is important to avoid any implication that attendance at a clinic might mean institutional placement. The clinic should not do work which would take fees from private practitioners. The psychiatrist in each clinic should be chosen first and should have responsibility for selecting other members of the staff.

(b) The professional work of all mental hygiene clinics should be under supervision of the Department of Institutions and Agencies and if necessary the law should be modified to give the Department authority to set qualifications for all such clinics, private or public.

(c) No clinic should be established without first securing the coöperation of the medical profession in the area served.

(d) General hospitals are favored as sites for future mental hygiene clinics. The atmosphere of such a hospital is psychologically favorable and the availability of technical facilities for somatic diagnosis and treatment are additional desiderata.

(e) Mental defectives and institutional parolees should be dealt with in special clinics apart from mental hygiene outpatients.

(f) Information about epileptics developed at mental hygiene clinics should be transmitted to the staff at the State Village so that they may have the opportunity of making specialized contacts with such patients.

(g) General hospitals should be encouraged to provide facilities for the early treatment of nervous and mental patients.

(h) Clinics discontinued during the past few years should be re-opened.

(j) Programs should be worked out for the development, in connection with these clinics, of conferences open to school teachers, social workers and medical practitioners.

SCHOOL HEALTH

Wilson G. Guthrie. M.D., Chairman, Newark

During the past year no meeting was held by the Advisory Committee on School Health.

TROPICAL DISEASES

Christian P. Segard, M.D., Chairman, Leonia

As a follow-up of the Report for 1944-45, the Committee submitted a brief resume on Schistosomiasis. It was the feeling of the committee that this disease might soon make its appearance on U. S. soil. The resume was printed in the State *Journal* for November, 1945. The committee believes that an abstract of papers on Tropical Diseases might well appear every other month in the State *Journal*. The American Society of Tropical Diseases is being consulted on this point and it is hoped their coöperation may be secured.

The Committee feels that the forthcoming summer season is most likely to show an increase in certain tropical diseases, particularly malaria. They suggest that the profession be more alert this year than heretofore and report as early as possible any case which has been ruled as "positive" or "suspicious".

In view of the close liaison between the Mosquito Control Commission and the Health Department, it would also seem essential that, in reporting the case, the exact location of residence be stipulated. This will lend effectiveness to locating mosquito sources.

TUBERCULOSIS AND ADULT DISEASE CONTROL

Abraham E. Jaffin, M.D., Jersey City

Recommendations from the Advisory Committee on Tuberculosis and Adult Disease Control, presented to the Sub-Committee on Public Health and the Welfare Committee on January 13th, have already appeared in *The Journal* (February 1946, page 58).

The Chairman of the Committee has worked with other members of the Society in the consideration of several "Christian Science Amendments" to Assembly Bill 47—to reorganize the State Department of Health.

Dr. Kalb, a member of the Committee, heading up the nutrition group, has been instrumental in organizing meetings throughout the state on various phases of nutrition. Meetings have been held in Newark, Trenton and Moorestown. They are demonstrations for the lay public, usually called by the Woman's Auxiliary of the County in which the meeting is held. The program consists of a sound movie, a speaker from the Department of Agriculture, a talk by Dr. Kalb and a round table discussion.

VENEREAL DISEASE CONTROL

Baxter A. Livengood, M.D., Chairman, Woodbury

There is nothing special or new to report except the progress in the previously established program. The Committee has responded to all requests made to it from the various branches of the Bureau of Venereal Disease Control of the State Department of Health.

MEDICAL PRACTICE

AUXILIARY MEDICAL SERVICES

W. James Marquis, M.D., Chairman, East Orange

No formal meetings were held during the year. There are several problems confronting the Auxiliary Medical Services, first of which is relations with the hospitals. Since there is a committee working on this it would not be wise to complicate things by having another committee cover this same problem. The question of transferring the Auxiliary Medical Services from the hospital service plan and putting them in the medical services plan is a perennial one.

There is also the problem of taking care of the veterans and unfortunately the committee on the Auxiliary Medical Services did not have a chance to work on this but it is hoped that the committee next year will be able to change the present set-up so that the payment for these services will be on the same basis as for other medical services.

CONTRACT PRACTICE

Andrew C. Ruoff, M.D., Chairman, Union City

This Committee is one that functions largely at the call of the President, when matters regarding contract practice present themselves. In the past year, every one of our members was apparently satisfied with the *status quo* in respect to contract practice. Under the circumstances, it did not become necessary to call a meeting of the Committee. As Chairman, I did, however, appear at the regular meetings of the Sub-Committee on Medical Practice. In such capacity, I participated in discussions relative to the matters coming before that Committee, and particularly concerning the contract which The Medical Society of New Jersey made with the Veterans Administration. I do not wish to imply, in this report, that any suggestions on my part materially altered that contract, but I did seek to get the Hudson County Medical Society in line in connection with this urgent, important matter.

My Committee stands ready to coöperate with the President of the Society in so far as its duties necessitate.

DISTRIBUTION OF MEDICAL CARE

R. M. Grier, M.D., Chairman, Pleasantville

The work of this committee the past year has been chiefly on that portion of its duties pertaining to veterans.

The problem of Medical Care for Veterans was so extensive that it was made a major project of the Welfare Committee. Our efforts were overshadowed by special committees. We did all in our power to assist.

HOSPITAL RELATIONSHIPS

Watson B. Morris, M.D., Chairman, Springfield

No regular meetings were held during the year. The one important item we were requested to consider was the Wagner-Murray-Dingell Bill. Because of the fact that the Society had already given it considerable study, and had printed a pamphlet with reasons for not approving it, the committee studied this report and agreed with it in every way.

INDUSTRIAL HEALTH AND HYGIENE

J. M. Carlisle, M.D., Chairman, Westfield

The Committee on Industrial Health has been active during the past year in the continuation of its general task of improving medical facilities and services in industry. We have worked closely with the smaller industries seeking medical personnel for full-time or part-time services, to enable them to improve and maintain the health and safety of industrial employees.

Reorganization of the New Jersey State Department of Health has been a matter which your Committee has supported, since it has been our conviction that such a reorganization would afford many advantages, not the least of which would be improved relations between the Department and the medical profession. We believe that the facilities of the Bureau of Industrial Health of the State Department should be supervised by a physician, rather than by a layman as it now is, and should make available to industries the professional services for which the Bureau was organized by your Committee.

Your Committee has been active in assisting returning veterans in obtaining full-time or part-time employment in industry where their "on the job" services can be devoted toward improvement of the workman's health. In all instances we have attempted to emphasize that the industrial physician's services should be essentially *preventive*, and he must be familiar with the hazards of the individual work stations.

Unemployment sickness compensation has been discussed by your Committee and we have made several constructive suggestions, although we are not convinced of the advisability of the proposed unemployment sickness compensation legislation as it now stands.

The question of certification in the field of Occupational Medicine has been a subject high on our agenda. We are working with the American Medical Association and the American Association of Industrial Physicians towards this objective.

Since one of the largest pools of potential industrial workers consists of those who have had pulmonary tuberculosis and since tuberculosis is principally a disease of those between the ages of 15 and 45, which age group corresponds with the great bulk of our industrial workers, we have strongly recommended the desirability of medical supervision which includes the following:

1. X-rays of all employees.
2. X-rays of all applicants.
3. Employment of all individuals with minimal healed tuberculosis.
4. Employment in *dust free* surroundings of patients showing moderate involvement who are healed.
5. Referral of each patient with active tuberculosis to his family physician for care and study with the recommendation that such a patient receive treatment in a local tuberculosis sanatorium. No one who has had clinical tuberculosis should be employed unless he has been clinically free of signs and symptoms of active tuberculosis for a period of one year.
6. Placing of all tuberculous workers under medical supervision and their assignment to specially selected work stations without transfer to another work station except with permission of the physician in charge.
7. Complete physical examinations, x-ray of the chest and laboratory studies annually on all such employees and a similar examination after each period of absenteeism due to illness.

Numerous special lectures and several papers have been given on the subject of Occupational Medicine. We have continued our regular courses of academic lectures both on Industrial Nursing and on Industrial Medicine.

LABORATORY MEDICINE

Asher Yaguda, M.D., Chairman, Newark

At the request of the New Jersey Society of Clinical Pathologists, The Medical Society of New Jersey has recently established a Committee on Laboratory Medicine, advisory to the Sub-Committee on Medical Practice. The members of the committee are:

Asher Yaguda, Chairman, Newark
Hobson Davis, Paterson
S. A. Goldberg, Newark
Carlos Pons, Asbury Park
Frank Konzelmann, Atlantic City

This committee has not had time to organize as yet, but it is the hope of the members of the committee to improve the scope and quality of Laboratory Medicine in the State and to institute activities which will place the practice of Laboratory Medicine in its rightful position as a specialty of the Practice of Medicine.

MEDICAL CARE OF THE INDIGENT AND LOW WAGE GROUP

GEORGE BLACKBURNE, M.D., Chairman, Newark

Medical care of the indigent has presented no new problems during the year. Care for the indigent is provided for in a satisfactory way in practically all municipalities through the State Municipal Aid Administration under an arrangement by which the State bears a proportion of the cost based upon the tax ratables of each community. This arrangement is in operation in towns which total 90 per cent of the state's population.

During the year the size of the indigent load remained practically static. In January, 1945, there were registered on the state welfare roll 5,028 cases representing 8,110 individuals. In December, 1945, there were 5,080 cases representing 9,318 persons.

During the past three months, due to changing economic conditions, the load is rising more rapidly. In February there was an increase in total cases of about 5 per cent and of total persons about 10 per cent, indicating that borderline families with a large number of dependents are feeling the effects of the present wave of unemployment. About 500 cases were added during January and February.

Our Medical Service Administration continues to operate the City of Newark Plan for the benefit of the indigent and medically indigent of Newark and the Farm Security Medical Plan for the low income farmers being rehabilitated by the federal government. It stands ready to expand its activities whenever the opportunity presents itself.

During the year, upon recommendation of the committee, Municipal Aid Administration agreed to reimburse municipalities up to the following fee schedule: office calls $1.50, day house calls $2.50 and night house calls made after 8 p. m. $4.00. This should represent the minimum fees paid by any municipality. Many municipalities pay a higher fee, bearing the additional expense without reimbursement from Municipal Aid Administration. As of March 1, 1945, the City of Newark agreed to pay fees for day house calls of $3.00 and for night calls received and made after 8 p. m. $5.00. These fees are now payable by Medical Service Administration under provisions of the City of Newark Medical Plan.

NURSING AND NURSING EDUCATION

A. CHARLES ZEHNDER, M.D., Chairman, Newark

The activities of the Committee on Nursing and Nursing Education during the past year have been mostly consultative with the Nursing Association and other committees of The Medical Society of New Jersey. Our committee did not find it necessary to hold any meetings as there have been no important matters to consider. Due to the exigencies of the times we have decided to hold meetings only when absolutely necessary.

PHARMACEUTICAL PROBLEMS

CHESTER I. ULMER, M.D., Chairman, Gibbstown

One meeting of the committee was held during the year. It was a joint conference with the Committee on Professional Relations of the State Pharmaceutical Association. Every member of the Committee on Pharmaceutical Problems was present. Cordial and coöperative relations continue between the pharmaceutical and medical professions in our State.

MULTIPLICITY OF NAMES

The committee discussed the matter of correcting the multiplicity of trade names for standard pharmaceutical products. A resolution concerning this problem was presented at the October, 1945, meeting of the Welfare Committee. Two communications have been received concerning the resolution, one from the American Pharmaceutical Association and the other from the A. M. A. Council on Pharmacy and Chemistry. From the A. M. A. letter we quote, *"Everything possible should be done to avoid the confusion that arises from the use of many protected names for a single substance."*

Recently a meeting between representatives of the Council on Pharmacy and Chemistry of the American Medical Association and members of the staff of the American Pharmaceutical Association was held at which this subject was given consideration.

It was agreed that steps should be taken to avoid confusion that arises from the use of different trade names for the same substance, and that as far as the group was concerned it would make every effort to promote the use of a common name instead of a coined special name. It was also agreed that the manufacturer could protect his interests by appending the name of his own firm to the common or usual name of the drug product which he markets.

It is anticipated that a joint statement from the American Medical Association and the American Pharmaceutical Association or representatives of these Associations will be prepared for publication and it is hoped that this will aid in correcting the situation.

NEW JERSEY FORMULARY

Many physicians have become somewhat careless in their prescription writing and have become mere distributors of proprietary preparations. The New Jersey Formulary can be used effectively to perfect prescription writing. More physicians in the State should make use of the N. J. F. and its helpful list of practical prescriptions.

No early issuance of a new edition is planned. If any member of the State Society has misplaced his copy of the Formulary, a new one can be secured by writing to the Executive Office.

PRIVATE PRACTICE

Harry N Comando, M.D., Chairman, Newark

No meeting was held this year, as the projects usually considered by this Committee were fully and ably covered by other committees and agencies of the Society.

WORKMEN'S COMPENSATION

William K. Harryman, M.D., Chairman, Hackensack

The Chairman of this committee wishes to report that there was only one committee meeting held during the year, namely on March 3rd, 1946, to consider any legislative matter that might be of interest to our committee and that had been forwarded to us.

The only one who attended this meeting beside myself was Dr. Cloud of Englewood. This was very disappointing in view of the fact that ample notice had been sent to all members. However, we took up the matters that had been presented to us and reviewed the material sent to us by Dr. Quigley.

We also considered a matter that had been presented to me by the Advisory Committee of the Department of Labor, of which I am a member, concerning revision of the Hernia Act. We rendered an opinion concerning this. Otherwise it has been very quiet.

APPROVED AGENCIES

MEDICAL SERVICE ADMINISTRATION OF NEW JERSEY
MEDICAL-SURGICAL PLAN OF NEW JERSEY

Norman M. Scott, M.D., Medical Director, Newark

The above named organizations are non-profit medical service corporations organized by the Society to carry out its program for improving the distribution of adequate medical care.

Medical Service Administration is designed for the benefit of any group whose medical care is payable by government funds.

Medical-Surgical Plan is designed for the benefit of employed, self-supporting persons overtaken by catastrophic illnesses, and operates on a voluntary prepayment insurance basis.

The National Picture: It is not our function to present or discuss legislation now pending in our National Congress, which is designed to establish national compulsory sickness insurance. We do call your attention to the ever increasing popular sentiment in favor of some form of sickness insurance and to the fact that our political leaders are not unmindful of this sentiment. From the standpoint of many of our political leaders, if there is a better solution for the problem than compulsory sickness insurance, the burden of proof is upon the medical profession. They look to us for guidance. This places the medical profession in a position where it must take a greater interest in the subject of medical economics, and must evolve its own solution for this problem if the tragedy of national compulsory sickness insurance is to be averted.

At this time voluntary medical care plans organized by the medical profession are in operation in twenty-nine states and have a combined enrollment of over two million persons. They represent the constructive program of the medical profession in its attempt to evolve a proper answer for this problem. That they have been successful in demonstrating the ability of the profession to evolve its own solution is evidenced by the action of the 1945 House of Delegates of the American Medical Association.

The House of Delegates of the American Medical Association on December 5, 1945, adopted by unanimous vote the following recommendation of its reference committee:

"Accordingly the Committee recommends that the House of Delegates of the American Medical Association instruct its Board of Trustees and Council on Medical Service and Public Relations to proceed as promptly as possible with the development of a specific national health program, with emphasis upon the nation-wide organization of locally administered prepayment medical plans sponsored by medical societies."

It is too early at this writing to predict in detail the final organizational and functional picture of the proposed program.

The A.M.A. has established within the Council on Medical Service and Public Relations a Bureau of Voluntary Medical Care Plans, for which a Director has been appointed. The function of this Bureau, as we understand it, will be to study the problems of voluntary medical care plans, to disseminate information concerning these Plans, to carry on a public relations program relating to these Plans, to establish the standards for approved Plans which Plans shall be privileged to use an insignia of approval issued by the Council, and to encourage and assist state and county societies in the organization of new Plans.

With the approval of the Board of Trustees of the American Medical Association there is being organized Associated Medical Care Plans, Inc. This new organization will be composed of member plans approved by the Council on Medical Service and Public Relations. The functions of this organization will be to promote the welfare of its member plans, to promote uniformity, coördination and reciprocity between Plans and to exchange information as to methods and techniques. Its member Plans will be limited to those approved by the Council on Medical Service and Public Relations. Its governing body will be a Commission of nine members of which three will be members of the Council on Medical Service and Public Relations of the American Medical Association.

The experience of our program in New Jersey during the past year has been as follows:

MEDICAL SERVICE ADMINISTRATION OF NEW JERSEY

Medical Service Administration operates the following Plans:

I. The Farm Security Plan

II. The City of Newark Plan

III. The Veterans Plan for Service-Connected Disabilities

Farm Security Plan:

This Plan is designed to assist low income farmers, without assets upon which to borrow, who are being rehabilitated by the Federal Farm Security Administration. It represents the only opportunity so far offered in this State to deal with the rural problem or with a Plan providing for home and office care on a prepayment insurance basis. The subscription cost is $16.00 to $24.00 a year depending upon the size of the family, and payable directly by the family. It provides payment for home and office care as ordinarily provided by general practitioners. The fees are $1.50 per office call and $2.50 per house call. In previous years it was necessary to pro-rate physicians' fees in this Plan, but during the past year full fees have been paid each month and a small surplus has been accumulated. This may be due to two reasons: first, the novelty of calling upon the physician or calling him to their homes has worn off, and second, many of the illnesses present in this group at the onset of the Plan have been corrected or their recurrence prevented by more adequate medical care and health guidance. As the economic condition of the farmer has improved, the number of subscribers has decreased, but we recommend the continuance of the Plan during the next year. It has proven to be of definite assistance to these farm families and has been a source of income to the profession.

Mean Number of Families Enrolled	283
Mean Number of Persons	1,149
Earned Subscription Income 1945	$5,905.59
Claim Cost 1945	5,555.53
Earned Subscription Income per Family	20.87
Claim Cost per Family	19.63
Earned Subscription Income per Person, per Month	.43
Claim Cost per Person, per Month	.40
Reserve in Farm Security Account:	
December 31, 1944	774.62
December 31, 1945	1,122.94
Increase in Reserve	$ 348.32
Proration of Physicians' Fees 1945	None

The City of Newark Plan:

This Plan, sponsored by the City of Newark, was designed to assist those persons whose names appear on the relief rolls of the City by providing payment for medical care rendered those persons when confined to their homes with illness. It has been in operation for three years, paying $2.00 per day home call and $3.00 per night home call. It is a reimbursement, rather than an insurance plan, the City reimbursing Medical Service Administration for money expended in payment for care rendered. During the past year the number of persons on relief and our experience with them was as follows:

Relief Clients	
Number of persons on City Relief Rolls, January, 1945	1,777
Number of persons on City Relief Rolls, December, 1945	1,870
Mean number on Relief Rolls, 1945	1,719
Cost per Person in 1945	$1.51
Cost per Person per Month, 1945	.126

Two years ago at the request of the City the Plan was extended to include the medically indigent of the City, medical indigency being determined by the social workers of the City Department of Health. It is impossible of course to estimate the number of medically indigent in the city. The following figures pertain only to those persons classified as medically indigent when applying for medical care under the Plan. There has been a marked increase each month in the number of persons so classified. The "medically indigent" must be distinguished from the indigent on relief rolls.

Medically Indigent treated in January, 1945	132
Medically Indigent treated in December, 1945	368
Cost of Care in January, 1945	$ 305.00
Cost of Care in December, 1945	$ 873.00

On March 1, 1946, the City increased the fees paid under this Plan to $3.00 per day call and $5.00 per night call to the indigent and medically indigent.

We recommend the continuance of this Plan.

Veterans Plan for Service-Connected Disabilities:

On February 8, 1946, Medical Service Administration signed a contract with Veterans Administration to provide medical care of service-connected disabilities among veterans to be rendered by private physicians in the offices of physicians, homes of the veterans or in civilian hospitals within reasonable distance of the veteran's home. The Plan was placed in operation on March 15, 1946. The contract, fee schedule and other information has been

published in current editions of the *Journal*. At this time the experience of the Plan has been too short to warrant a report. A supplementary report will be rendered at the time of the annual meeting.

MEDICAL-SURGICAL PLAN OF NEW JERSEY

Medical-Surgical Plan was incorporated in 1942 and started operating July 1, 1942.

The Plan is designed to assist self-supporting, employed persons overtaken with catastrophic illnesses. For practical purposes a catastrophic illness is defined as an illness requiring treatment as a bed patient in hospital. Certain exceptions to this definition have been made during the past year which allow the Plan to pay for eligible obstetric services rendered in the home at time of delivery in cases where the patient cannot obtain hospital accommodations, for eligible tonsillectomies performed in the office of the physician, for emergency surgery performed in the outpatient departments of hospitals without admission for bed occupancy and the emergency treatment of traumatic accidents rendered anywhere within 24 hours of the receipt of injury.

The old contracts of the Plan, which provided that Participating Physicians would deem as payment in full the amount payable by the Plan for services rendered patients admitted for ward or semi-private accommodations, are being replaced as rapidly as possible by our new contract on the expiration date of each old contract. This process will be completed in June, 1946.

To promote common understanding we quote in their entirety the sections of the new contract governing full payment and credit payment by the Plan.

"Section IV. When Plan Payment Is in Full for Eligible Medical and Surgical Services:

"Except as otherwise provided in this contract, payment by the Plan to Participating Physicians shall be deemed to be in full for medical and surgical services eligible for payment under this contract if the patient shall have been admitted to an approved hospital for either a semi-private accommodation (not exceeding four beds per room) or for a ward accommodation, as regularly so classed by the hospital selected, and without change to private accommodations unless made at the instance of the hospital or physician."

"Section V. When Plan Payment Is Not in Full for Eligible Medical and Surgical Services:

"Payment by the Plan shall not be deemed to be in full for medical and surgical services eligible for payment under this contract:

"(1) If the patient shall have been admitted for private accommodation, not exceeding one bed per room; or

"(2) If the patient (otherwise than at the instance of the hospital or physician) shall have transferred to such private accommodation after having been admitted for either a semi-private or ward accommodation; or

"(3) If the patient shall have been admitted for a semi-private or ward accommodation but shall have agreed to pay the Participating Physician an amount in addition to that payable by the Plan, except that no such additional amount shall be payable to the Participating Physician if, for the twelve calendar months immediately preceding the month in which the hospital admission for the medical and surgical services occurs, the income of the subscriber, enrolled under a Single Contract, is less than $2,000; or the income of the subscriber, enrolled under a Family Contract, is less than $2,000 plus $500 for the first enrolled dependent (wife [husband] or child) plus $250 for each additional enrolled dependent; or

"(4) If the patient shall have been admitted for any type of accommodation and shall have been attended by a duly licensed physician who is not a Participating Physician; or

"(5) If the patient shall have been admitted for a semi-private or ward accommodation but shall have failed to disclose to the Participating Physician the existence of this contract prior to such physician's agreement to render the medical and/or surgical services, except that no additional amount shall be payable to the Participating Physician if the income of the subscriber is less than as stated in Section V (3).

"In any cases to which any of the above five subparagraphs of this Section may apply, the only benefit available under this contract (toward, but not in excess of, the physician's charges to the patient for such eligible medical and surgical services) shall be payment by the Plan of the amount then payable by it to Participating Physicians for such services, and the Plan shall not be liable for any balance."

Enrollment:

The enrollment in the Plan as of December 31 of each year of operation was as follows:

December 31, 1942	4,999 persons
December 31, 1943	16,427 persons
December 31, 1944	30,427 persons
December 31, 1945	49,441 persons

(As of March 31, 1946, enrollment was 56,047.)

The Plan has had a successful year in that it has paid for all eligible services rendered in accordance with its schedule of benefits, has paid all expenses from earned income and has set aside a satisfactory amount of reserve. The obvious defect is its slow growth. It must increase its enrollment more rapidly if it is to fill the needs of New Jersey.

The following table depicts our comparative experience for each of the two years ending on December 31:

	1944	1945
Earned Subscription Income	$187,708.74 (100 %)	$326,900.26 (100 %)
Claims Paid and Accrued	135,605.75 (72.2%)	208,288.36 (63.7%)
Operating Expenses	35,504.03 (18.9%)	57,056.63 (17.5%)
Reserve	16,598.96 (8.9%)	61,555.63 (18.8%)
Average Exposure for Year	24,302 persons	42,058 persons
Cases Treated	2,215	3,426
Claim Incidence per 1,000 Persons	91	81
Total Number of Enrolled Groups	191	265

STATE BOARD OF MEDICAL EXAMINERS OF NEW JERSEY

E. S. HALLINGER, M.D., F.A.C.S., Secretary, Camden

During the period of January to December, 1945, the Board examined one hundred and seven applicants for a license to practice medicine and surgery. Sixteen of the applicants were graduates of osteopathic colleges.

The Board also examined three applicants for a license to practice chiropody.

Results of these examinations are indicated in Table I.

TABLE I.—STATE BOARD EXAMINATIONS IN 1945

	Total	Passed	Failed
MEDICAL			
United States			
Graduates of Medical Schools	73	73	0
Graduates of Osteopathic Schools	16	15	1
Canada	2	1	1
Italy	12	3	9
Great Britain	2	2	0
Russia	1	0	1
Lebanon	1	1	0
CHIROPODY			
United States	3	3	0
	110	98	12

All candidates were full citizens of the United States.

Two hundred and thirty-six licenses were issued to applicants for endorsement of a license from another state, or a diploma from the National Board of Medical Examiners, who presented credentials to prove they could meet the requirements for examination in force in New Jersey at the time they were examined.

TABLE II.—LICENTIATES BY ENDORSEMENT

Countries	Total
United States	177
Canada	5
Great Britain	6
Austria	23
Germany	9
Italy	6
Hungary	5
France	2
Switzerland	2
Russia	1
Total	236

All credentials covering medical and hospital work submitted to the Board were verified before a license was issued.

The laws governing the practice of medicine and surgery, osteopathy and chiropractic, do not provide for an annual registration. The board does not, therefore, know whether the number of licentiates in the state now in practice is increasing or decreasing.

TABLE III.—Endorsements to Other States, Licentiates Deceased and Reports of Suspension or Revocation of Licenses

Physicians—Endorsed to Other States	54
Osteopaths—Endorsed to Other States	6
Chiropractors—Endorsed to Other States	3
Medical—License Revoked	1
Medical—License Restored	1
Medical—Petition for Reinstatement Denied	1
Medical—Revocation or Suspension Pending	3
Medical—Complaint Dismissed	1
Physicians—Deceased	80
Osteopaths—Deceased	4
Chiropractors—Deceased	2
	156

Annual registration would give the Board accurate information in regard to the number of physicians practicing in New Jersey and would enable the licensed physicians to assist the Board in enforcing the law by reporting unlicensed practitioners in their vicinity.

The laws governing the practice of chiropody and midwifery do provide for an annual registration and our records show an increase of nine in the number of chiropodists registered on November 1st, 1945, and a decrease of twenty-seven midwives for the same period.

ENFORCEMENT

Following is a brief report of the Board's activities in enforcing the laws which they administer:

Court Cases—Violation of Medical, Etc., Laws	
Convicted, Pleaded Guilty or Settled	24
Lost, No Appeal	3
No Service	1
Pending in the Courts	12
Decision Reserved	2
Total Actions	42

Cases—Supreme Court	
Lost by Board—Writ of Certiorari Allowed by Supreme Court—Pending	1

Hearings Before Board (Medical only)	
License Revoked	1
License Restored	1
Petition for Reinstatement Denied	1
Revocation or Suspension Pending	3
Complaint Dismissed	1
Total Hearings	7

INVESTIGATIONS AND INSPECTIONS

	No. Investigated
Druggists Practicing Medicine	25
Prescribing Herbs and Drugs	22
Unlicensed Medical Doctors	6
Unlicensed Chiropractors	50
Licensed Chiropractors Exceeding License	4
Licensed Osteopaths Exceeding License	1
Unlicensed Chiropodists	1
Naturopaths	7
Physio-Therapists	17
Laying-On-of-Hands	1
Medical—Revocation	4
Optometrists Practicing Medicine	1
Electro-Therapists	3
Chiropractor Practicing under Another Name	1
Miscellaneous	27
Total Investigations	170

Total Number of Investigations and Inspections Made	170
Total Number of Visits Made and Treatments Received in Making the Investigations and Inspections	877
Average Number of Visits per Investigation	5.1

COUNTY SOCIETIES

ATLANTIC

Edward Guion, M D., President, Northfield

The first post-war year of the Medical Society of Atlantic County has probably been the most successful one in its existence. Our service men returned in good numbers, and many new members have been welcomed into our Society. Meetings were well attended due, to some extent, to the returnees, but in no small measure to the high caliber of our scientific programs.

The Program Committee under the chairmanship of Dr. David B. Allman has secured for us many speakers of note including Dr Samuel Alexander, President of The Medical Society of New Jersey; Dr. William Bates, President of the Pennsylvania Medical Society; Dr. William Harvey Perkins, the Dean of Jefferson Medical College; Dr. Thomas A. Shallow, Dr. Stanley P. Reimann, Dr. Thaddeus Montgomery, and others of equal stature.

The Legislative Committee of Atlantic County has worked in close coöperation with that Committee of The Medical Society of

New Jersey and our Senator and Assemblymen have at all times stood firmly with organized medicine.

A special meeting of the Society was devoted to the care of the veteran. At that meeting, the New Jersey Plan was adopted and approved after very interesting and enlightening talks by Dr. Norman M. Scott and Dr. R. C. Fagley. About 80 per cent of our members have signified their intention of participating in this work as Designated Physicians of the Veterans Administration.

All other Committees of the Society have functioned well and the Officers have received the loyal support of every member.

The April meeting of the Society will be preceded by a banquet honoring all medical veterans of the County who are to be guests of the Society at that banquet, which will precede the regular meeting. One of our members, Lt. Col. Hilton S. Read, will be the "Guest Speaker" of the evening and, in honoring him, the Society honors all of its veterans whom he typifies.

A huge outing is planned for the month of June at one of the country clubs when further testimonials will be extended to our returned veterans.

Plans are being made by the Society to entertain The Medical Society of New Jersey at its Annual Meeting in May and the ground work has likewise been laid for the American Medical Association Meeting in 1947.

We feel that Organized Medicine has been definitely advanced in this County during the past year.

BURLINGTON

THOMAS J. SUMMEY, M.D., President, Moorestown

The year 1945-1946 has been one of partial reconversion from war-time activities with a return to monthly evening meetings and monthly scientific programs. Of a membership of fifty-nine, twenty-four were in the Armed Forces. Of these twenty-four, three gave their lives in service; namely, Dr. Allen Hemphill, Dr. Carlton Hogan and Dr. John Siddall. Most of the men in the Service have been discharged but a few have not returned to this county.

Excellent scientific programs have been given at the monthly meetings, which included papers on: Guillain-Barre Syndrome; Medical and Surgical Experiences in the China-Burma-India Theatre; Coronary Artery Disease; Diagnosis and Treatment of Carcinoma of the Stomach; Migraine; Dermatoses found in the returning war veterans; Recent Advances in Endocrine Therapy; and Public Health Problems related to the General Practitioner.

For a "rural" county, we feel that we are doing an excellent job of carrying on modern, scientific medicine in spite of the shortage of physicians, nurses and hospital beds. There is an approved Cancer Clinic and each of our two small hospitals is equipped for x-ray diagnosis, deep therapy and radium treatment. Plans are under way for enlarging these hospitals to a total capacity of about three hundred beds as compared with twenty-five beds only two decades ago. We have excellent specialists and consultants and are trying to encourage the general practitioners, who are necessarily the backbone of all good medical work, especially in a rural area.

CAPE MAY

GEORGE M. BROOKS, M.D., President, Cape May Court House

In spite of war-time conditons, Cape May County Medical Society has held regular meetings for the purpose of discussing local, state and national affairs. At the December meeting Dr. Frank W. Konzelmann was a guest speaker and gave a most interesting discussion on laboratory diagnosis.

Three members of the Society, who have been in the service, have returned to their practice and four new physicians have located in the county and become members of the Society.

At our last meeting, it was decided to have four meetings during the year, since it was felt that four good meetings would be more interesting than eight unsuccessful meetings. It is hoped that this year will see our Society on a more sound basis.

CUMBERLAND

GEORGE N. THOMAS, M.D., President, Vineland

During the fiscal year beginning April, 1945, we have had five interesting scientific meetings. Our last meeting was held in Vineland and consisted of a tour of the Kimble Glass Company plant. The members were divided into three groups and a guide showed and explained to each group how glass was made, especially those types used in the preparation of containers for ampules, syringes, etc. At the end of these tours, which consumed about one hour, three top members of the scientific ware department gave interesting talks on the manufacture of glass.

We were glad to welcome back from the service this year the following physicians:

Vineland: Dr. Charles Cunningham, Dr. Kenneth Corson, Dr. Anthony Magolda.

Bridgeton: Dr. Frank Aiken, Dr. E. C. Green, Dr. William Kratka, Dr. H. B. Loder, Dr. Anthony Pino.

Millville: Dr. James K. Knowles, Dr. Sol Rosen.

The following deaths occurred:

Dr. M. F. Sewall, Bridgeton
Dr. Kenneth Bauman, Millville

The following new members were admitted to the Society:

Dr. Herbert Anastor, Vineland
Dr. Mario A. Pastore, Vineland
Dr. A. H. Hirsch, Vineland
Dr. Joseph G. Kolbe, Millville

At the last regular meeting of our Society, held on February 12 at Vineland, we subscribed to insurance coverage which will protect all officers of the Society and the Society as a whole against law suits.

ESSEX

WILLIAM D. CRECCA, M.D., President, Newark

The Essex County Medical Society has had a very active year, initiating its activities last May with the National Physicians Committee sponsored Health Forum. It was questionable at that time whether the Murray-Wagner-Dingell Bill would come out of committee, but we now understand that the American Medical Association will be invited to testify shortly before the Committee on Education and Labor, holding the hearings on S. 1606. We know how our legislative representatives in Congress stand on this pernicious form of legislation, and I believe as far as New Jersey is concerned, we have little to fear. We must be on our guard for as President Madison once said, "It is proper to take alarm at the first experiment on our liberties."

We have initiated in our county, and this is probably the first county to do so, a central blood and plasma bank to meet the needs of over 800,000 people. The program is under way and has the endorsement of our County Freeholders, the Red Cross Chapters and several civic organizations. This is a community program that should be duplicated in every county where there are many public and private hospitals in need of blood or plasma. The State Department of Health has agreed to allow for distribution some of the surplus plasma in possession of the American Red Cross. This will be of tremendous scientific as well as economic help to the people of our State.

Our County Society has taken active steps in providing facilities for rehabilitating our veteran physicians. The Veterans Liaison Committee and our Postwar Rehabilitation Committee have coöperated wholeheartedly with all agencies working on our local as well as our state problems pertaining to the lay veteran as well as to the physician.

The Graduate Instruction Committee has done a magnificent job and has started a very comprehensive program of graduate instruction which we have needed for several years.

We not only have provided for refresher courses for our veterans, but have sponsored graduate teaching by recognized medical authorities. We expect in the near future to enlarge the scope of graduate teaching under the guidance of a recognized teaching institution.

The Committee on Medico-Legal Testimony has been active in our county and has received the endorsement of our local and county judges. While this committee has no statutory or punitive powers, it intends to prevent deliberate misrepresentation of scientific facts by doctors who attempt to make a farce of justice and lower the prestige of our profession.

The Essex County Medical Society, as a

component part of the State Society, welcomes its obligation in guarding the public health and welfare of our citizens. We wish to reaffirm our faith in American Medicine and shall, through our own initiative, adjust our post war program to the need of the public and deliberate judiciously our socio-economic problems as they arise.

GLOUCESTER

ISAAC N. PATTERSON, M.D., President, Westville

We have had our regular meetings with an increasing attendance, both because of the return of our members who have been in the armed services, and because of our programs, which have had a wealth of postgraduate subject matter of interest to the doctors of our communities. Our annual social session was well attended and was a success.

We have supported, to our fullest extent, all matters brought up by the State Medical Society.

Several new members have been added to our roster, and thus our membership has increased.

Plans are now being made for a "Welcome Home" dinner for our members who have been in the armed forces, in the late spring. This is in appreciation for the men who have been away and also tendered to those who did an admirable job at home.

I surely have appreciated the help and cooperation from our own members, and also extend to the State Society my appreciation for its help.

HUDSON

HUGH H. TYNDALL, M.D., President, Weehawken

The component society of Hudson, now entering the fourth quarter of the 1945-46 official year, continues to participate in the various activities endorsed by the State Society and also to promote the interests of its members locally. Our annual report to March 15, 1946, is as follows:

1. The current year is marked with distinction in that it is witnessing the return to civilian life and practice of a large number of our members who served with the armed forces. In reinstating these men, we are giving them any assistance it is possible for us to give, and in some instances we have helped find suitable offices and homes.

2. Six of our scheduled eight monthly meetings have taken place. On our scientific programs we have been honored to present Dr. Roy B. Henline and Dr. Norman Jolliffe of New York City, and Dr. Reginald H. Smithwick of Boston. Attendance at regular monthly meetings has been steadily improving, largely due to the fact that our returned veterans are resuming their places among us.

3. While the annual report of the Membership Committee will not be complete for several weeks, we have already added thirty-three names to our official list for this year, and have reinstated eight former members. In addition, four members of other component societies have transferred to Hudson—all of which contributes markedly to our strength and to our spirit. We report with regret, however, that death has removed eleven members from our midst since last spring.

4. The Medical Economics Committee under the chairmanship of Dr. Londrigan has continued its endeavors to defeat the compulsory sickness insurance measure contained in the latest Wagner-Murray-Dingell bill. On January 4, 1946, a petition in triplicate, addressed to New Jersey senators and representatives, was sent to all active members of the Society, with the request that they obtain the signatures of as many of their patients as possible. The coöperation in this movement of those now receiving medical care is an indication that the laity will not depart voluntarily from the present system.

5. A subcommittee of the Medical Economics Committee, headed by Dr. Andrew C. Ruoff, studied the subject of medical care of the veteran in this county and submitted a comprehensive report to the State Society for consideration in its recommendations to the American Medical Association.

6. The Society through the Executive Committee sponsored the publication of a Roll of

Honor in the four county newspapers. Two separate lists comprised this roll; one list contained the names of those of our members who are still in service, while the other list showed the names and present addresses of those who have resumed civilian practice. A request that former patients return to the physicians whose names appeared in the latter list was appended. It is planned that this Roll of Honor shall be published in the daily papers at stated intervals until all our men have been released from military service and have resumed the practice of their profession.

7. In the interest of establishing prompt and adequate care of World War veterans in Hudson County, our Society invited Dr. R. C. Fagley, Chief Medical Officer, Regional Office of Veterans Administration, to address our members on January 8, 1946. Dr. Fagley described the activities of Veterans Administration in New Jersey, and appealed to physicians in general practice as well as those in special fields to notify the Administration of their willingness to become designated, fee-basis physicians to care for returned wounded and physically unfit veterans. For their convenience, postcards were prepared and mailed to all members of the Society, to be filled in and forwarded. We are gratified by the spirit of whole-hearted coöperation in the plan as demonstrated by our members. Individual replies have been tabulated and retained for reference in the office of the Society. Two hundred ninety of our members have signified a willingness to coöperate.

8. The Committee for Postgraduate Medical Education has confined its efforts this year toward the setting up of programs in the hospitals of the county, under which returned medical veterans were afforded the privilege of attending weekly lectures, participating in ward rounds, and of being present as observers in hospital clinics.

9. The Legislative Committee has given support to the same committee of the State Society in the matter of bills pending in the New Jersey Legislature that affect public health and are of significance to the medical profession.

We look forward with pleasure to the first post-war Annual Meeting on May 21, 22 and 23, 1946, and hope that the approaching official year will see the solution of some of medicine's pressing problems of today.

MERCER

Richard T. Buckley, Jr., M.D., President, Hightstown

The fundamental, essential and principal purpose of a medical society is "to advance Medical Science . . ." and, with this purpose in view, the obligation assumed upon taking the President's chair imposes a responsibility that must be carefully and conscientiously supported.

The appointment of Committee members, upon whose shoulders rests the burden of providing wholesome topics for discussion, is of great importance, and I take considerable reflected pride in the accomplishments of the Program Committee, appointed for the year 1945.

We have been extremely fortunate in obtaining speakers of pronounced ability in the field of scientific research medicine and surgery, whose subjects for discussion embraced the following:

1. Modern methods in diagnosis and treatment of pulmonary tuberculosis, with films showing typical and atypical pulmonary infections.
2. Diagnosis and management of peptic ulcer and its complications.
3. Tropical diseases and the general practitioner of medicine.
4. Use and contra-indications of blood and blood derivatives in medicine and surgery.
5. The Rh factor in obstetrics and transfusions.
6. Thoracic surgery. (This was a most interesting subject not only from a scientific standpoint, but from the fact that one of our own members recently discharged from the service, presented the subject most ably and with assurance based upon definite conscientious application in his capacity as Supervisory Chief in many of the surgical units organized abroad, providing a wealth of material for research and study.)
7. Asthma, hay fever and other allergies.
8. Chemical analysis of compounds entering into the process of producing penicillin.
9. Influenza. Anaesthesia in new born.
10. Clinical use of penicillin and streptomycin.

Our Membership Committee was kept busy examining the numerous applications presented and conscientiously performed their duty, providing us with 12 new members.

The Public Relations Committee brought to a climax the subject of infant and maternal mortality in the successful appointment of a Special Committee whose function provided

procedures for lowering the mortality. Result was a most gratifying report, statistically arranged and submitting recommendations to our hospitals, governing premature and maternity cases with proper care.

In conjunction with other committees the Public Relations Committee provided industrial surveys, in which the x-ray of civilian employees for pulmonary tuberculosis was advocated; the Cancer Control Campaign with indorsement by the Society of the Field Army work, and the development of a set of minimum requirements for Cancer Prevention Clinics to be established in our hospitals was an outstanding feature.

The usual routine of the Legislative Committee in keeping pace with Workmen's Compensation Acts and chiropractic legislation was further activated by the Chairman of the State Legislative Committee in the numerous hearings bearing upon health bills, consuming considerable valuable time graciously contributed by this important committee.

The importance of the medical administration and care of veterans was thoroughly discussed and approval of the State Society plan of such care was unanimously sanctioned.

The Emerson Survey submitted, discussed and accepted by the Society provided a great incentive for a more intensive study of many of our public health problems, as well as calling attention to the need of greater hospital and nursing facilities. The survey resulted in the appointment of a "Health and Hospital Council" composed of outstanding civilians interested in public welfare as well as hospital and staff representatives.

We take great pride in the knowledge that, by our appropriation of $4,000 toward the defraying of the expense of enlarging the Executive Assembly Rooms, we are privileged to join the State Society in providing a dignified official professional building.

The Committee, especially appointed to provide the necessary care of polio cases during the recent epidemic, functioned in a most efficient manner, characteristic of all the committees, whose appointment it was my honor and privilege to assume. Their final report was most gratifying, and the recommendations, accompanying the report providing for a follow-up procedure and plans for future control of any epidemic arising in our midst ,were unanimously commended and approved by the Society.

The enumeration in detail of the successful activities carried out by all the committees will be too exhausting, and I have endeavored to set forth the outstanding accomplishments, for all of which I desire to express my gratification to the committee members, and my sincere appreciation of the whole-hearted coöperation on the part of the entire Society.

MIDDLESEX

C. Howard Rothfuss, M.D., President, Woodbridge

The current year's activities of the Middlesex County Medical Society may be summarized as follows:

In January, 1945, Dr. C. F. Church of Squibbs Institute for Medical Research spoke on *Penicillin Up to Date.* In the following month, Dr. Michael Scott of Temple University Medical School reviewed the *Neurosurgical Management of Intractable Pain,* while in March we had a talk by Dr. H. C. Bell of the University of Pennsylvania Medical School on the *General Hospital Management of Psychiatric Cases.*

Our April meeting was highlighted by an illustrated talk on *The Diagnosis and Management of Gonorrhea* by Dr. P. S. Pelouse of the University of Pennsylvania. In May, Dr. Bart James of the New York Postgraduate Hospital spoke on *Occupational Dermatoses* and in June we heard Dr. Henry Sage Dunning review *Surgical Problems Arising in Treatment of Diseases of the Jaw.* This joint session of M.D.'s and dentists concluded our spring program.

In the fall, the Society resumed activities with a talk on the *Clinical Importance of the Rh Factor.* The essayist was Dr. Philip Levine. This meeting also featured the appointment of a Veterans Committee to study means whereby Middlesex County could most effectively participate in the program of medical care for veterans. The State Society's plan was approved. In November, 1945, Mr. John Debus of the N .J. Pharmaceutical Association spoke on the *Joint Responsibility of Physicians and Pharmacists.* This was a joint meeting of pharmacists and physicians. The year came to a close with an annual dinner meeting at which officers were elected. Speaker on that occasion

was the state's former governor, Harold G. Hoffman, then a Lieutenant Colonel in the Army of the United States.

As the program indicates, the year afforded our membership a rich and varied professional diet. Nearly all aspects of medicine and surgery were covered and the position of physicians in the total professional community was emphasized by our two joint meetings with other groups.

MONMOUTH

Granville L. Jones, M.D., President, Marlboro

The year of transition from war to peace has naturally been an eventful one for us in Monmouth County, as well as elsewhere. A large part of our activity has had to do with the return of military personnel to civilian life—either our own members, or the veteran in general.

Of the 58 men who wore the uniforms of the Army and Navy, only eight are still in service. Two of our members will not return. Major Edmund Kanses of Rumson was killed in action on July 11, 1944, and Lt. Commander Howard B. Mason of Freehold died July 14, 1945, in the St. Albans Naval Hospital as a result of service in the Iwo and Lingayen Gulf actions. We are deeply conscious of our obligation to the memory of these men. It can never be discharged save by the creation of a new world in which such reckless waste of human life cannot occur.

Tentative plans have been made to compile a volume on the war services of Monmouth County physicians, with the Auxiliary collaborating.

The most important activity of this Society during the year was the initiation of the Monmouth County Plan for Veterans Medical Service. In 1944, under President Otto Holters a committee was appointed to coöperate with the County Veterans Service Committee in making plans to facilitate the return of demobilized men to civilian life. The Committee consists of Drs. Jones, Herrman, Nichols, Pregnall, Freedman, and DeVita. From experience under the E.R.A., free choice of physicians was thought to be feasible, and was, of course, considered of utmost desirability. To reduce the necessity of time-consuming travel and hardship and to assist the veteran in selecting his physician intelligently, a screening or triage clinic was proposed. This was to determine the need for medical care, where it might be best obtained and the type of physician best qualified to render it.

This plan was submitted to the Veterans Administration in May, 1945, and discussed in an interminable series of conferences, letters, and conversations. After General Hawley took office, the proposal was brought to his attention by Mr. Homer Rogers, Regional Manager. Drs. Jones and Herrman went to Washington on October 12, discussed it with General Hawley, and it was promptly accepted on a trial basis. We began under this plan in early November, 1945. It was working fairly well but before the end of the three months' trial, the contract for the State Plan was signed, and our plan was superseded. However, we have reason to be proud of the fact that our County plan has been given credit for being the prototype of all subsequent arrangements between the Veterans Administration and State Medical groups.

The screening clinic feature of the plan, while basically a good idea, has proven not feasible under Veterans Administration regulations and laws, and has been replaced by a clinic for pension examinations only.

A matter at present under consideration in Monmouth County is the establishment of an executive office and the employment of an Executive Secretary. The great increase in membership, from 140 in 1940, to 170 at present, the piling up of paper work and correspondence, and the many ways in which a full-time Secretary could serve as a public relations officer have led us to study seriously a proposal to raise the dues to provide the funds necessary to finance such a step.

MORRIS

Daniel J. Geary, M.D., President, Morristown

Morris County held meetings in October, 1945, and in January and March of 1946, and will hold its Annual Meeting in June. These sessions were held at the various hospitals in the county and the programs were presented by the staff of each hospital. The first one was held at Morristown Memorial Hospital. It was a continuation and comparison of the report of last year on anterior poliomyelitis. In January, the meeting was at Dover General Hospital, and the speaker was Dr. Richard Swain of Newark. The March meeting was held at All Souls Hospital, Morristown, and it was put on by the returned veterans who presented the surgical and medical problems encountered in the various theatres of war.

Attendance has been much better than in previous years due to the additional men who returned home and also because of the lightened burden of those who remained in civilian status. Our total membership in Morris County, including Honorary Members, is 120. Of these, 45 were in the armed services. All have returned except 13. We have been fortunate in that we have had no casualties and no serious disabilities amongst these men.

Members of the Morris County Society have set up an emergency fund to be used, first, for the returned veterans who are in need of aid on their home-coming; when this emergency is over, it will be used as a reserve to take care of needy doctors as the situation arises. We have a substantial sum in reserve and found that it has been useful and at present have applications from several members for a loan from this fund.

We have at hand, membership applications from fifteen doctors who desire to practice in Morris County.

During the past year, this Society has been active in plans for the returned veterans and we have adopted the State Plan for medical care of veterans. We had a very active committee under the chairmanship of Dr. Krause, in formulating fees for patients under control of the Welfare Board and have had meetings with the State Board of Children's Guardians in a similar capacity. These have not been settled but it is the wish of the County Society that the fees that were formulated at the time of the E.R.A. and have continued to the present, should be changed.

We suffered two deaths in the last year: Dr. John Zuck, of Netcong, and Dr. Edward Ackermann, of Dover, both very active in the practice of medicine and in the affairs of our Society. Morris County feels a deep loss at the death of these members.

We feel that with the men returning home from the services, our meetings can be more numerous and I am sure will be much better attended as is reflected in the increased attendance at our recent meetings.

OCEAN

Abraham Goldstein, M.D., President, Lakewood

The activities of the Ocean County Medical Society have not been affected much this year although more than 50 per cent of our members were in the armed forces. Meetings were held regularly and attendance showed marked improvement over the last few years. Due to shortage of physicians, it was necessary for those at home to do more work, especially during the recent epidemic of grippe and virus pneumonia, but all people in our county were well taken care of and no one suffered from lack of medical services.

As hostilities ceased, most of our members returned and at present we have only two or three left in the service.

We have had a few joint meetings with the Woman's Auxiliary, which has been active in the blood donors' drive, the cancer drive, the Red Cross drive, and other related activities.

Ocean County has the honor of having Mrs. Mabel E. Dodd, former president of the Woman's Auxiliary to the Ocean County Medical Society and now president of the Woman's Auxiliary to the State Medical Society, amongst its citizens.

Our legislative committee has communicated with our Senator and our Assemblywoman and they will coöperate with us in legislation favorable to our medical professions and to public health.

We of the Ocean County Medical Society are happy to welcome our members back from the armed forces and will celebrate our regular annual affair (which was dispensed with during the war) at the Laurel-in-the-Pines in Lakewood on April 6.

At our last meeting, some of our members serving with the armed forces related their personal experiences while in service and we intend to have the rest of those who served tell their stories at some later date.

We have had some new members and also some Junior members added to our membership during the past year.

PASSAIC

Howard H. Nye, M.D., President, Paterson

The year brought with it many problems of concern to the medical profession in our own county and throughout the country. The first of vital concern in Passaic County was the poliomyelitis epidemic, and the lack of adequate facilities to care for contagious diseases. This problem of long standing can be solved only by erection of a modern hospital, fully staffed and equipped to care for patients, not only in the acute phase of an illness but also those who require long convalescent care as well as cases of chronic illness. Following action by the Freeholders on September 19, 1945, to plan for erection of hospital units for rheumatic heart and poliomyelitis cases, special meetings were held and a committee appointed to assist the Freeholders in deciding upon the size, equipment and administration of the proposed hospital units. The Advisory Committee also recommended that the scope of the hospital should be extended to take care of the chronic diseases. A Rheumatic Heart Foundation has been the project of the Woman's Auxiliary for the past two years, and Dr. Julian Cohen and Dr. James Phelps of the Cardiac Committee have stressed repeatedly the need for adequate local care of these cases. Following a complete study of the need of a convalescent home, the Board adopted a resolution that this building be part of a post-war project of the County.

With the end of the war and the return of many of our physician-veterans to civilian practice, the Society made every effort to aid them in securing office space and in every other way. To date, more than three-fourths of the physician-veterans from Passaic County have returned and have been given a dues credit for their Society membership for the first full year following release from service.

Excellent programs were arranged by the Program Committee of which Dr. Wayne W. Hall is the Chairman and these programs were presented at the regular monthly meetings of the Society, which were well attended.

In June, 1945, The Second Judicial District of the State Medical Society sponsored a "Health Forum". Radio talks were given and a meeting held at the Central High School in Paterson. The principal address, "Your Health —Take Care of It the American Way", was given by Dr. Edward F. Stegen of Chicago, a recognized authority on social insurance. Other speakers on the Forum were Dr. Alexander, President of the State Society; Dr. Londrigan and Dr. Scott of Newark.

I wish to express the appreciation of the members of the Society to Dr. Budd, Editor of the *Bulletin*, who has carried on for the members of the Editorial Staff who were in the Service. The *Bulletin* has been published regularaly and contains many items of scientific and constructive nature along with other articles of local interest to our members.

The Maternal Welfare Committee has continued with the work of the Rh Negative Blood Donors Club. Since July of last year, members of this Club have aided in saving the lives of ten babies and two mothers who were afflicted with this unusual blood condition arising from the Rh special groups of blood. The Society is pleased with the result of this project, sponsored by the Maternal Welfare Committee.

The Cardiac Committee in coöperation with the Passaic County Tuberculosis League sponsored an excellent campaign to inform the laymen of a program for the control of Rheumatic Fever, by means of numerous talks and the publication of articles and advertisements.

Since, according to estimates, there will be approximately 600,000 World War II and 120,000 World War I Veterans in New Jersey, The Medical Society of New Jersey proposed that war veterans suffering from service-connected disabilities be cared for by civilian

doctors of their own choice. With this in mind. the membership was circularized by letter, asking their coöperation in the care of these veterans. Response to this request was excellent and the plan went into effect in March.

Graduate Courses have been planned and are held on Tuesdays and Fridays, 4:30 to 5:30 P. M., throughout April and May. Subjects chosen were Internal Medicine, Cancer, Obstetrics and Pediatrics. A Course on Fractures of the Extremities is planned for May on Saturday mornings at various hospitals. These lectures will be given by outstanding men in their fields and it is hoped that the attendance will be good as we are sure that the papers will be exceptionally interesting and educational.

The Passaic County Medical Society marked with a deep sense of personal loss the passing of Dr. Andrew F. McBride and Dr. William Spickers. Dr. McBride was President of our County Society in 1913 and of the State Society in 1928; he was always interested in maintaining our high standards of professional service and ethics and worked hard to keep them so. The community has lost a fine man, one who accomplished much in many fields and one whose integrity made him respected, honored and admired by all races, religions and parties. Dr. Spickers was a member and past President of the County Society, a scholar, and devoted student of medicine. He was greatly devoted to surgery and his intellectual honesty, medical common sense and surgical courage made him admired and respected by all. We shall miss Dr. McBride and Dr. Spickers—leaders, faithful workers and staunch friends.

The Society has during the past year examined many legislative bills. These were presented to the members by letters and through publication in the *Bulletin*.

The Passaic County Society is now endorsing the fund-raising campaign of the American Cancer Society. Dr. William M. Sullivan was elected president of the Passaic County Chapter and many meetings have been held to discuss and plan the organization to make the chapter permanent, and the drive a success.

I wish to thank the officers of the Society and the Chairmen of the various Committees for their coöperation, their attendance at the Welfare Council Meetings and their interest and assistance in the affairs of the Society.

SOMERSET

E. F. Hird, M.D., President, Bound Brook

During the past year the Somerset County Medical Society has been addressed by Dr. Philip Levine on *The Rh Factor* and by Dr. Eugene Katzin on *Blood Transfusions and Blood Bank Procedures.*

Six new doctors have been added to the membership of this society and we have also made it possible for physicians assigned to the Veterans Hospital at Lyons to join the Somerset Society as associate members.

SUSSEX

F. Herbert Lushear, M.D., President, Branchville

The major portion of the activities of the Sussex County Medical Society during 1945-1946 consisted of reinstatement of members returning from the armed forces and reorganization of committees. Most local business of our Society was purposely postponed until as many returning members resumed their active status as possible.

Among the current items upon which action was taken was the readjustment of fees for services rendered Sussex County Welfare patients and the negotiation of a contract with the State Board of Children's Guardians for services rendered their clients under various plans.

The Society endorsed the State Society's plans for care of returning veterans and made committee appointments as recommended by the State Society.

Two clinical meetings were held. One at Franklin Hospital, Franklin, N. J., and the other at Alexander Linn Hospital at Sussex, N. J. At each meeting the clinical program consisted of presentations of interesting cases prepared by staff physicians.

UNION

Walter F. Phelan, M.D., President, Elizabeth

The Executive Office received requests for speakers on rheumatic fever, compulsory health insurance, the American Medical Association's plans for voluntary health insurance, rehabilitation of the returning veteran, advice on services rendered veterans with service-connected disabilities and one request came from Connecticut for a speaker on the Rh Factor. We were able to furnish all the speakers requested.

The Veteran Physicians Committee was formed to aid the returning veteran in obtaining an office, house or giving any assistance he might need in his return to civilian practice. The committee has requested every doctor who knowingly has patients who were formerly patients of a veteran to see that those patients are returned to the original physician . An advertisement has been published in six of the county newspapers announcing the return of our 123 members to date. When the remainder return the advertisement will be repeated.

We have been fortunate in our Scientific Program this year and we think our committee has brought to our meetings some of the best medical speakers in the country.

The Legislative Committee has kept members informed of all pending legislation and the doctors have been very active in combating bills that would lower the high standards of medical practice. A large number of officers and members went down to Trenton last fall to hear officers of the A. M. A. discuss the latest revision of the Wagner-Murray Bill.

In January we had a most interesting meeting on compulsory health insurance with representatives from the C. I. O., Physicians Forum and several of our most prominent State Officers as speakers. Guests were physicians ,nurses, dentists and pharmacists. It was the unanimous feeling that compulsory health insurance will not solve our medical problems but that we can solve them on a voluntary basis and maintain free choice of physician.

Present pending legislative bills are Senate Bill 95 and Assembly Bill 45 which would permit graduates of substandard medical schools to practice in New Jersey. The Auxiliary worked closely with the Society members in contacting not only the veteran physicians and their wives but all of our members to see that they wrote to the Senator and four Assemblymen of Union County. The Society also sent resolutions against these bills to various veteran organizations.

At the Trenton meeting last fall, we heard of the various plans offered for the care of the veterans with service-connected disabilities and when the final plans approved by the State Society were brought before our Society for our approval it was given unanimously. To date over two hundred and fifty members have signed the agreement.

The Executive Secretary has attended 160 meetings this year connected not only with health but with education, nutrition and housing problems as these must always be a part of any good health program. Each year more lay organizations, realizing that physicians are also interested in the same problem, have requested that members of the Society be appointed to serve on their Committees or Boards dealing with these subjects and where their advice might be of great value.

The routine work remains the same as always for the Executive Staff—correspondence, filing, mimeographing, bookkeeping, keeping all records up to date including a list of all physicians in the county who are not members of the Society and managing the Medical Service Bureau. The Society now has 405 members. We have twenty-two members still in service.

WARREN

Harry B. Bossard, M.D., President, Phillipsburg

On June 21, 1945, the Warren County Medical Society met with the staff of Warren Hospital at the hospital. Dr. Joseph Londrigan, Chairman of the New Jersey Physicians' Committee; Dr. James Norton, Chairman of the Board of Trustees of the State Medical Society, and Dr. William F. Costello, one of the Trustees of the Medical Society, were present and discussed the objects of the National Physicians' Committee.

Our October meeting was held in the Hotel Belvidere, October 16, at which time officers were elected.

The January meeting was held January 22, 1946, at the Elks' Club, and was addressed by Dr. Norman Scott, Medical Director of Medical Service Administration, who spoke of the Veterans' Medical Service Plan. The Society went on record as approving the plan as outlined by Dr. Scott.

VETERANS CARE PROGRAM

LOCAL HOSPITAL CARE

Care of veterans in local hospitals by private physicians is authorized by the Veterans Administration as follows:

1. Emergency conditions, on presumptive evidence of service-connection (such as malaria, tropical fevers, battle wounds, etc.).
2. Conditions for which the veteran has been granted a service-connection by the Veterans Administraton. In these cases, the patient should be able to produce a "Notice of Award" which will state the nature of the service-connected condition.
3. If the veteran's claim is pending, care in a local hospital may be authorized only if the condition is emergent.

PROCEDURE FOR HOSPITALIZATION

Two forms are required for hospital admission. They are V. A. forms P-10 and R-9-1. These may be obtained at any office of the Veterans Administration or at Red Cross chapters, or at the posts of the veterans' organizations; or by telephone or letter addressed to Veterans Administration, 20 Washington Place, Newark.

In nonemergent cases, forms P-10 and R-9-1 must be submitted to the Regional Office at Lyons, N. J. If it is proposed that the private practitioner attend the patient during his hospitalization. this information should be transmitted with the forms—either by attaching a letter to that effect or by inclosing the Medical Service Administration *Request for Authority for Treatment.*

In emergency cases, the physician will call Dr. Rainone at the V. A. Regional Office (phone: Millington 7-0180). If emergency authorization for hospital care is granted, forms P-10 and R-9-1 must be submitted to the Regional Office within 72 hours after the hospital admission.

PHYSICAL EXAMINATIONS

Authorizations for physical examination are issued to the Medical Service Administration by the V. A. Separate authorizations are issued for each examination (except that laboratory procedures on the same patient may be grouped in a single authorization). Each examination will be designated by item number, name and cost; for example:

518—General Physical Examination $5.40

Medical Service Administration will transcribe the necessary data on one of its examination forms and forward it to the participating physician. Physicians accomplished in the required type of examination will be selected for this purpose and the Medical Service Administration will notify the veteran of the doctor to whom he is to report.

TREATMENT CASES

The veteran applies for authorization as follows: He completes form R-9-1 and takes it to his physician along with the M. S. A. form *Request for Authority for Treatment.* The practitioner fills out the latter form, indicating the amount and type of medical service necessary to provide adequate care to the patient during the current month. These two forms are then mailed directly to Regional Office, Veterans Administraton, Lyons, N. J. Forms may be procured at American Legion, V. F. W., D. A. V. and Amvet posts, at Red Cross chapters and at the various V. A. offices. Medical Service Administration will also make these blanks available at hospitals and, if requested, at physicians' offices. On receipt of the forms at Lyons, the office there determines the eligibility of the patient on the basis of service-connection. If the condition is considered service-connected, V. A. form 2639 is issued to the Medical Service Administration; this indicates the name of the practitioner chosen by the veteran as well as the type, cost and nature of the service; for example:

08—Office Visit (General Practitioner)	$ 3.25
Visits authorized: 6	Total: 19.50

If a surgical procedure at a value of $50 or more is authorized, there will also be included, as separate items, authorization for anesthesia and surgical assistant.

EMERGENCY TREATMENT

If emergency treatment is needed, the patient or the physician will call Dr. Rainone (Millington 7-0180), who will mail the forms to the veteran or to the doctor. Upon return of these forms to the Regional Office, eligibility will be determined. Authorization is then granted in service-connected cases for the emergency treatment and for all intervening treatments.

TREATMENT REPORTS

Medical Service Administration will transcribe the required data on one of its *Treatment Report* forms and mail it to the physician. The M. S. A. will also notify the veteran. With the *Treatment Report* mailed to the doctor, will be included the *Request for Authority to Con-*

tinue Treatment bearing the name and claim number of the veteran. On this blank, the practitioner may request authorization for services necessary during the following month. Remember that the V. A. operates on a monthly budget and requests for treatment must be on a monthly basis. When the M. S. A. receives the filled out *Treatment Report* (from the doctor), this report will be forwarded to the V. A.

BILLING

Medical Service Administration will bill the Regional Office at monthly intervals. This bill is itemized, indicating in each case type of service, date of authorization, date of service, name of veteran, claim number and cost of each item.

EXPERIENCE TO DATE

Medical Service Administration has been operating the Plan since March 15. Full cooperation of all participating physicians is essential. Without such coöperation, the veteran will not receive the highest standards of care; and incidentally, without it, the Medical Service Administration will not receive the financial support necessary to operate the plan.

Medical Service Administration is expanding as rapidly as equipment can be obtained and personnel trained. At present ten new employees are giving full time to the Plan. The Plan must be supported by the eight per cent of the scheduled fee derived from cases completed and paid for by Veterans Administration. At present the Plan is processing 250 to 300 cases a day. The return of case reports from physicians is averaging 60 to 70 cases per day. Income from the present return falls far short of supporting the Plan.

The small proportion of returned reports may be due to two factors: (1) that many veterans are not reporting for examinations or treatment or (2) that physicians are not returning their reports promptly. We urge that doctors return completed physical examinations and treatment reports as promptly as possible.

It is customary, in new cases, for Veterans Administration to issue an authority for one general practitioner call and to issue authorization for multiple calls or other services only after the report and recommendations of the attending physician is rendered.

It may be that some practitioners do not think it worth while to report on a $3 call. This is another factor in the small proportion of returns. But it is essential that these single visit reports be returned with your recommendations concerning future medical care. If they are not returned, care of the patient is interrupted and the veteran must apply all over again for authority for treatment. And the M. S. A. loses the 25-cent income from the call. Remember, it costs us as much to process a three-dollar case (from which M. S. A. receives 25 cents) as to process a hundred-dollar case (from which it derives eight dollars). And the hundred-dollar case is a rarity. Medical Service Administration cannot afford to lose the income allowed on the many three-dollar cases.

SPECIALISTS

Certain problems concerning specialists have come up recently. The Plan provides free choice of practitioner for treatment purposes. If the veteran designates his doctor on his application form, we refer the case to that physician. Otherwise our form is sent to the patient with instructions to choose his physician. Frequently the authorization as issued by the Veterans Administration provides for a general practitioner's fee when the designated physician is a specialist, or the veteran with an authorization for general practitioner fees, simply chooses a specialist. The specialist may object to accepting general practitioner's fees. This is difficult to correct. We think this is a fair compromise: let the specialist accept the general practitioner's fee as authorized, but when requesting continued treatment * of the case, specify that the visits are to be at specialist's rates.

If you are listed as a specialist with the V. A., this procedure will correct the defect with only small financial loss to the doctor; and the veteran will have satisfactory service. On your report of treatments submitted to the M. S. A., be sure to list by date each authorized service. Only services listed will be paid for by the Veterans Administration.

CORRECTION

There is an error in the fee schedule. Item 2115, which now reads "urethral stricture, dilatation of", should read:

2115 Ureteral stricture, dilatation of . . . $37.80

The organization costs and operating expenses during the early weeks of the Plan have been a heavy expense to The Medical Society of New Jersey. It is hoped that, without undue delay, the Plan can be placed on a self-supporting basis.

NORMAN M. SCOTT, M.D., Medical Director,
Medical Service Administration.

*An appropriate request form is enclosed with each report blank.

Tuberculosis Abstracts

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XIX **May, 1946** **No. 5**

GENERAL hospitals, whether they recognize the fact or not, have an ever-present tuberculosis problem among patients and personnel. Those institutions that maintain a search for the disease are protecting both groups from a hazard which is always greatest when least suspected. Tuberculosis control in general hospitals has proved to be both practical and easy. It should be one of the accepted and practised community health measures.

TUBERCULOSIS AND HOSPITALS

The method by which tuberculosis is discovered for treatment is known as case finding. This has developed in step with medical progress. In the period before and immediately after World War I, the horse-and-buggy days of the stethoscope changed to the Model-A days of an X-ray for every suspected case.

Modern case finding has leaped ahead with the speed of lightning. During the past decade, the technical developments in X-ray methods, forced to completion by the needs of the armed services, have brought efficient, fast X-ray service into the low-cost brackets. It is now possible to afford a method which one cannot afford to disregard.

Case finding in hospitals is the perfect combination of method and place. Hilleboe and Morgan, in their manual on mass radiography, have stated concisely that a hospital and an industry are the two best places to practice mass case finding by X-ray. There are about 16,000,000 hospital admissions a year, and the patients who go there expect to be examined carefully.

A complete program for control of tuberculosis in a hospital must include:

1. The space for the care of tuberculous patients, newly admitted and recently discovered.
2. A simple, efficient routine of infectious disease precautions for protection of the patients and personnel.
3. A complete case-finding program for patients and personnel.

The rationale and details of these approaches have been described in a manual "The Management of Tuberculosis in General Hospitals," published by the American Hospital Association in 1939, and revised in 1946.

Case finding in a hospital may be applied to two groups—the patients and the personnel. The patient group consists of all new admissions to the hospital, and all patients registering for the first time at the out-patient clinic. The personnel groups include the medical and nursing staffs, and all categories of hospital employees.

The ideal qualities of a method to be used for examination of new admissions must include speed, convenience, efficiency, low cost and permanence of record.

Only an X-ray method would have these qualities, and only miniature film of high quality would meet the tests of efficiency and cost. Miniature films in use now are the 35 mm. and the 70 mm. camera films, and the 4″x5″ X-ray film. A stereoscopic pair of any of these sizes is about as efficient as a 14″x17″ single film provided the new technical developments have been used. The cost of each can be as low as five to twenty cents, exclusive of the costs of film readings.

There are alternative methods, to be used when equipment for taking miniature films is not available. A 14″x17″ paper X-ray is slightly less efficient and costs about half as much as the 14″x17″ film, the standard of comparison. Fluoroscopy costs little and provides an immediate report, but it is less efficient, needs a specially trained operator and leaves no permanent record.

Supplemental film methods are used only to confirm or investigate the original findings. The

use of 14"x17" stereo films provides the best information when the original film or lesion is indefinite.

Case finding among personnel groups is done by the methods used for new admissions. In addition, it may be considered valuable to tuberculin skin-test student nurses, nurses in tuberculosis units, medical students, internes and residents. Original reactions can be checked at intervals so long as they continue to be negative. Recurrent X-raying of the personnel groups is necessary to a complete case-finding program. Four to twelve months is the usual interval.

Surveys of various population groups have shown that about one to three per cent have reinfection type tuberculosis. Pre-induction surveys for the armed forces show that an average of about 0.9 per cent have pulmonary tuberculosis in that age group.

In hospital surveys reinfection type of disease was found in 1.5 per cent to 2.3 per cent of the patients, with perhaps one-third of this amount called "active." The medical and nursing groups have shown variable levels of infection and disease, depending on rural or urban origin and duration of contact with patients. The levels rise rapidly during continued contact, often to a 100 per cent infection rate. The older nurses have been found to have from 2.5 per cent to such fabulous rates as 8.8 per cent reinfection type disease, and ward workers with many years of contact with patients may have up to 4.3 per cent disease. Non-contact workers have the same per cent as in the comparable local population.

The present status of hospital case finding can be judged from a survey of 934 teaching hospitals by a joint committee of the American Trudeau Society and the American Hospital Association in 1944. X-rays are being taken of student nurses by 85 per cent of the hospitals; of the medical residents by 28 per cent; of graduate nurses by 31 per cent and of the other employees by only 17 per cent. In spite of the war, 56 hospitals have begun routine case finding among new admissions. Of these, seven hospitals do not knowingly admit tuberculous patients.

The future prospects of case finding in hospitals should embrace 100 per cent of the hospitals. Routine case finding certainly will become widespread when the results have become known, when help becomes available, and when the equipment can be procured.

Practically, case finding will need to be explained. The medical staff and the hospital manager may approve of the program and methods, but the hospital board may need to be enlightened. A director is necessary for the planning and execution of a suitable program for each hospital. It helps if he understands tuberculosis work and will do no harm if he has some of the fervor of an evangelist.

In conclusion, case finding in a hospital finds tuberculosis—the first essential in any tuberculosis program. It provides the hospital with a knowledge of all of the tuberculosis within its walls. It improves the hospital's competency and removes a hazard to patients and personnel—the unrecognized case. It improves the diagnostic efficiency of the hospital, both for tuberculous and non-tuberculous disease. It is bound to improve community health. Case finding in hospitals, by hospitals, is certain to become a widely used procedure.

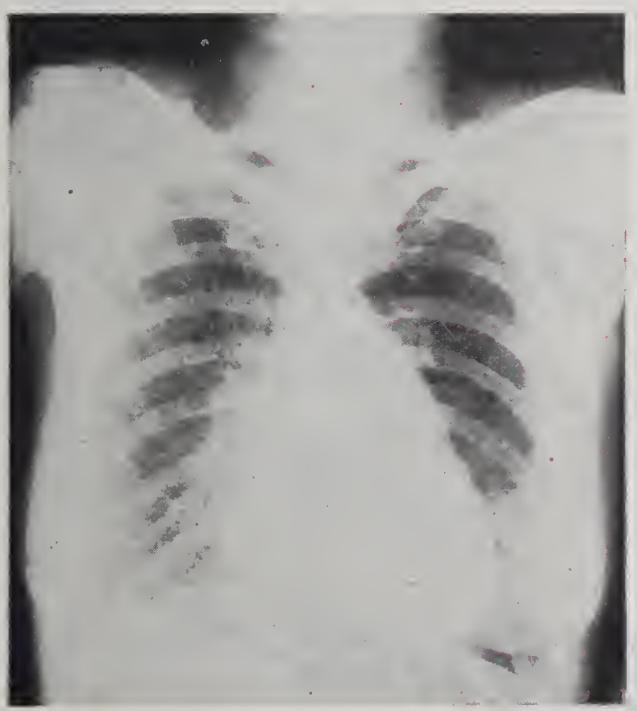
TB Search in Hospitals, W. H. Oatway, Jr., M.D. The NTA Bulletin for November, 1945.

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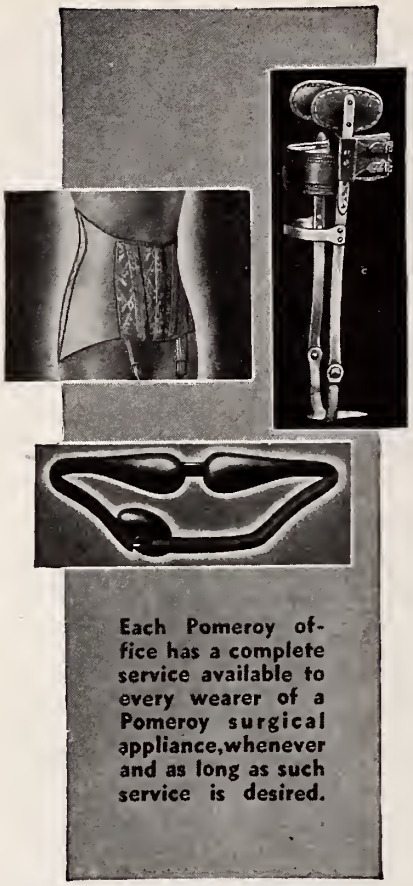
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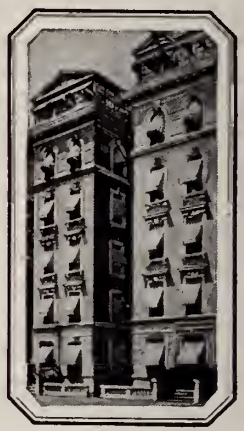
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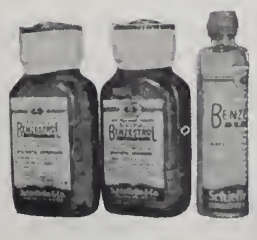
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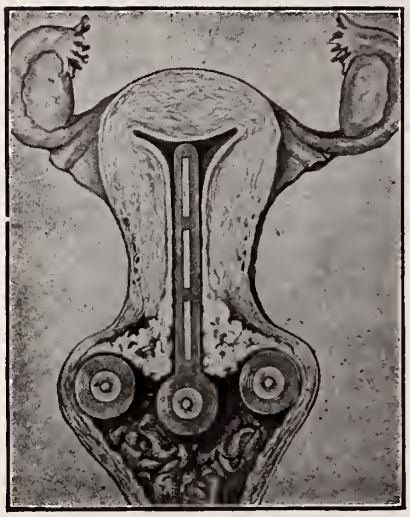
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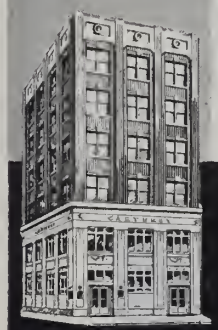
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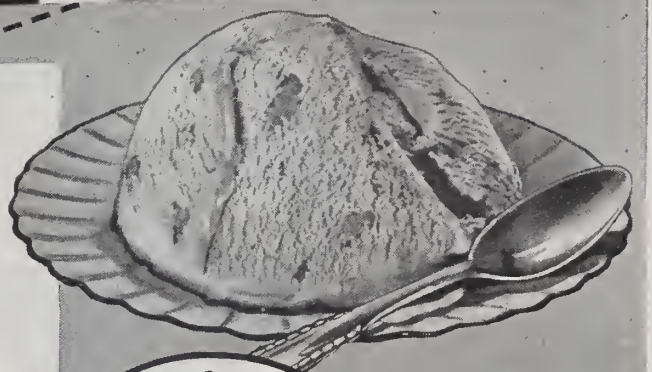
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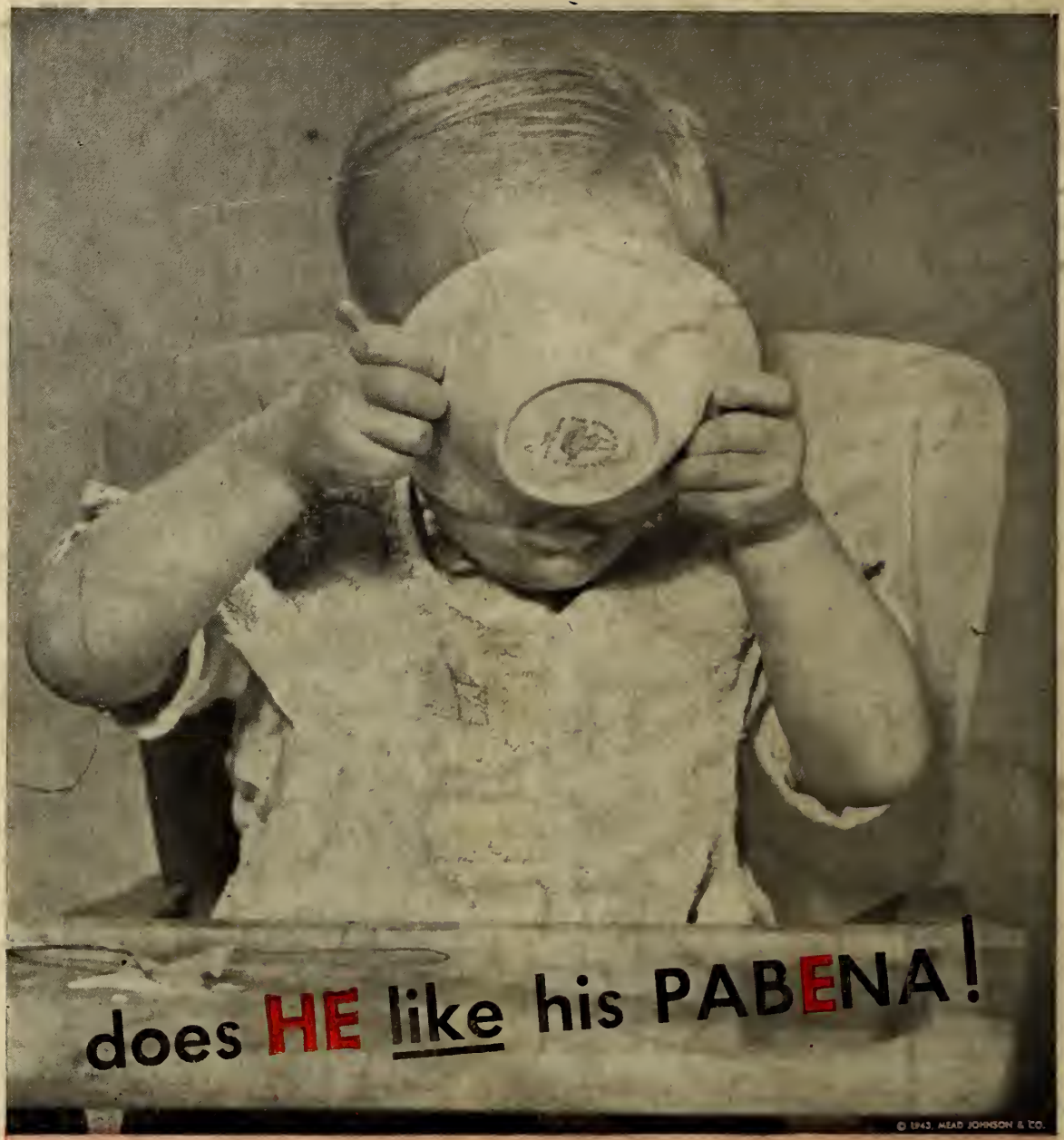


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Entered as second-class matter, September 5, 1906, at the post office at Orange, New Jersey, under Act of March 3, 1879.

VOL. 43, No. 6 JUNE, 1946 Subscriptions, $3.00 per Year Single Copies, 30 Cents

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Place of Publication, Printing and Mailing: 12 South Day St., Orange, N. J.

Editorial and Executive Offices of the Society: 315 West State St., Trenton 8, N. J.

Send all communications to the Trenton Office, telephone Trenton 5776

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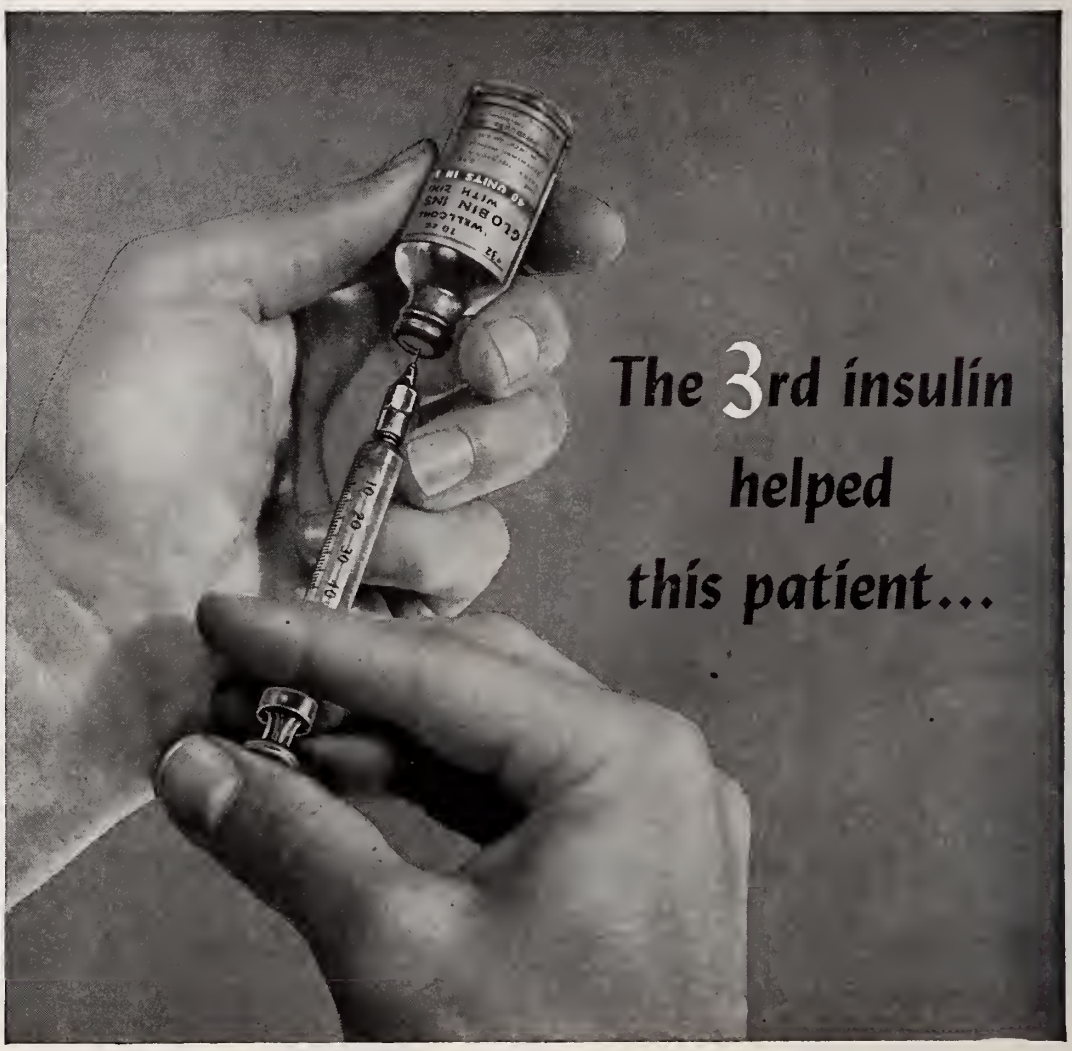
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TODAY, the physician treating diabetics, has the choice of three types of insulin. One insulin is rapid-acting but short-lived. Another is slow-acting but prolonged. Between them is the new 'Wellcome' Globin Insulin with Zinc, moderately prompt in starting, yet capable of sustained effect *for sixteen or more hours.* Such intermediate action is sufficient to cover the periods of maximum carbohydrate intake, and diminished enough by nighttime to minimize the likelihood of nocturnal reactions. Physicians do well to consider all *three* insulins when treating their diabetic patients.

'Wellcome' Globin Insulin with Zinc is a clear solution, comparable to regular insulin in its freedom from allergenic properties.

Accepted by the Council on Pharmacy and Chemistry, American Medical Association. Developed in the Wellcome Research Laboratories, Tuckahoe, New York. U.S. Patent No. 2,161,198.

Available in vials of 10 cc., 80 units in 1 cc., and vials of 10 cc., 40 units in 1 cc. Literature on request. *'Wellcome' Trademark Registered.*

'WELLCOME'
Globin Insulin
WITH ZINC

BURROUGHS WELLCOME & CO. (U.S.A.) INC., 9 & 11 EAST 41ST STREET, NEW YORK 17, N.Y.

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WHAT value have claims of superiority unless there is a difference in formula or process to justify such claims?

Take cigarettes for example.

PHILIP MORRIS Cigarettes are *made* differently. In the clinic as well as in the laboratory, the *advantages* of PHILIP MORRIS have been repeatedly observed, repeatedly reported by *recognized authorities* in leading medical journals. Yes, PHILIP MORRIS *claims* superiority . . . *and that superiority has been proved.**

May we suggest that your patients suffering from irritation of the nose and throat due to smoking change to PHILIP MORRIS—*the one cigarette proved definitely less irritating.*

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PHILIP MORRIS & CO., LTD., INC.,
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**Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154*
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60
Proc. Soc. Exp. Biol. and Med., 1934, 32, 241
N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.

TO THE DOCTOR WHO SMOKES A PIPE: We suggest an unusually fine new blend—COUNTRY DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

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fortified baby food



FORMULAC is a new baby food—a reduced milk in liquid form—fortified with sufficient vitamins and minerals to meet the nutritional needs of infants *without supplementary administration.*

FORMULAC was developed by E. V. McCollum, whose method of incorporating the vitamins and minerals *into the milk itself* lessens the risk of human oversight or error.

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FORMULAC is easily adjusted to meet each individual child's nutritional needs, by the addition of carbohydrates at your discretion.

FORMULAC—on sale at most grocery and drug stores —is priced within range of even low income groups.



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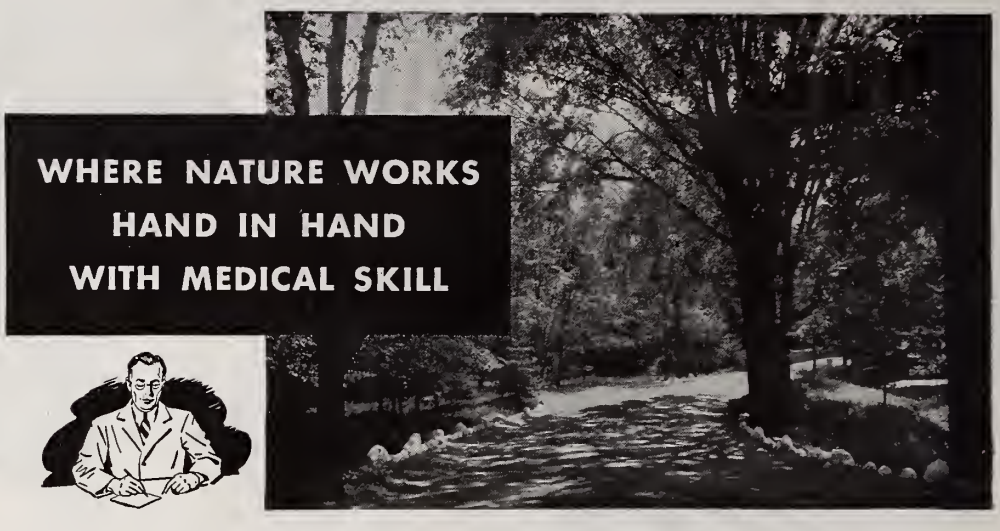
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PER-OS-CILLIN production at Roche Park has reached new peaks and your prescriptions for this excellent *oral* penicillin tablet can now be filled without delay. It is easy to take, stable, and well tolerated. Special long-acting buffers effectively protect its potency from destruction in the stomach. Per-Os-Cillin tablets, 25,000 units each, are available in tubes of 12.

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Dependability in Digitalis Administration

Being the powdered leaves made into
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D14

Dilaudid hydrochloride

(dihydromorphinone hydrochloride)

COUNCIL ACCEPTED



Powerful opiate analgesic - dose, 1/32 grain to 1/20 grain.

Potent cough sedative - dose, 1/128 grain to 1/64 grain.

Readily soluble, quick acting.

Side effects, such as nausea and constipation, seem less likely to occur.

An opiate, has addictive properties.

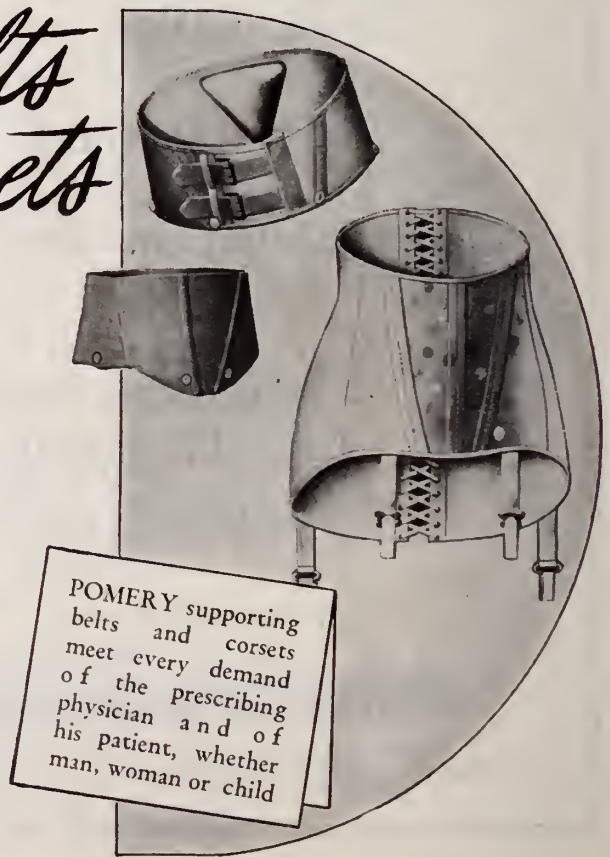
Dependable for relief of pain and cough, not administered for hypnosis.

● Dilaudid is subject to Federal narcotic regulations. Dilaudid, Trade Mark Bilhuber.

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Each supporting belt and corset is made to suit the individual requirements of the wearer, assuring correctness in fit, adequate support and personal comfort. POMEROY supporting belts and corsets are made for all forms of ptosis, post-operative support and pregnancy, as prescribed by the attending physician.



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AVAILABLE:

in solution for oral use

in ampuls 2 cc

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Use one of these Special Infant Foods

Altered Protein

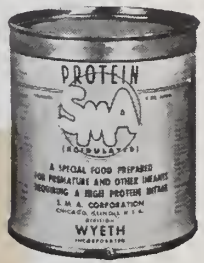


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WHOLE MILK

Particularly suited for infants and children allergic to cow's milk protein, Hypo-Allergic Milk has been rendered less allergenic by means of prolonged thermal processing. When reconstituted with water it is used in the same proportion as whole cows' milk.

POWDER—1 lb. tins **LIQUID 14½ oz. tins**

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PROTEIN
S-M-A*
(Acidulated)

The easily digested curd and liberal vitamin content makes Protein S-M-A a valuable aid in the management of premature and undernourished newborn infants. Also indicated in infant diarrhea and other conditions where a high protein intake is required.

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ALERDEX*
Protein-free Maltose and Dextrins

An all-around milk modifier especially useful in the hypo-allergenic milk diet of the infant sensitive to proteins, Alerdex is prepared from noncereal starch by a special procedure to eliminate every trace of protein.

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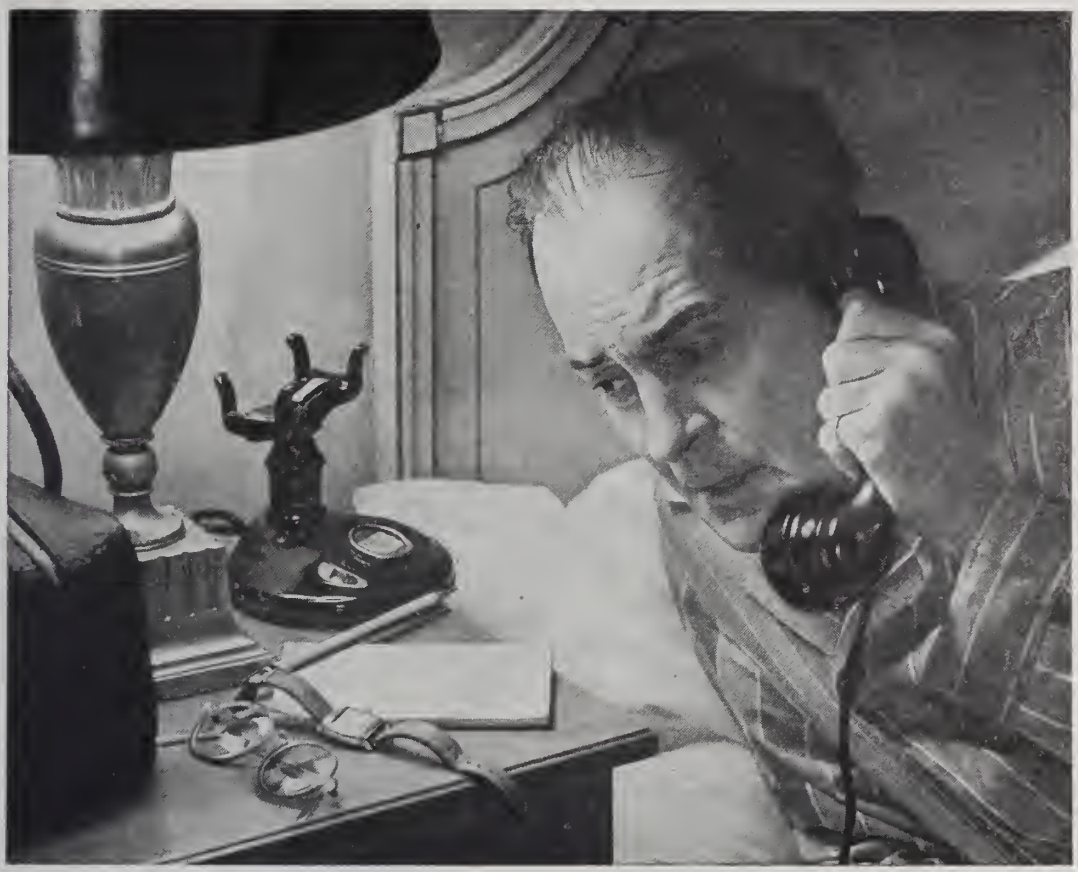
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You can assure women who seek to avoid the nervous tension, emotional imbalance and mental depression of the menopause that modern estrogenic therapy brings symptomatic relief in many cases without undue pain or waste of time. When Abbott's Estrone Aqueous Suspension is used, a few injections are sufficient in many instances to keep the patient in comfort for weeks. Clinical experiments have shown that out of 44 women who received three weekly treatments, 43 experienced relief for three to sixteen weeks.[1] As Estrone Aqueous Suspension is prepared in an aqueous menstruum, it can be administered to women who are sensitive to the oils commonly used in other estrone products. You may obtain Estrone Aqueous Suspension through your pharmacy in 1-cc. ampoules containing 2.0 mg. of pure crystalline estrone.

ABBOTT LABORATORIES, NORTH CHICAGO, ILL.

1. Freed, S. C., and Greenhill, J. P. (1941), J. Clin. Endocrinol., 1:983, December.

Estrone Aqueous Suspension, 2 mg.



"I'll Be Right Over!"

...24 hours a day your doctor is "on duty"... guarding health... protecting and prolonging life...

• Plays... novels... motion pictures... have been written about the "man in white." But in his daily routine he lives more drama, and displays more devotion to the oath he has taken, than the most imaginative mind could ever invent. And he asks no special credit. When there's a job to do, he does it. A few winks of sleep... a few puffs of a cigarette... and he's back at that job again...



According to a recent independent nationwide survey:

More Doctors Smoke Camels

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AUTHORITATIVE clinical investigators place strong emphasis on the importance of the barrier in conception control.

In a recent comprehensive report,[1] physicians indicated an overwhelming preference for the diaphragm and jelly method (93% of 36,955 new cases).

In keeping with these expressed opinions we continue to suggest that for the optimum in protection the physician prescribe the combined use of occlusive diaphragm and spermatocidal jelly.

You assure your patient a product of highest quality when you specify Ramses



Competent observers report:

"Jellies and creams used without mechanical devices yield relatively high protection, but studies have not proven them fully dependable to block the external os, or to invalidate all sperm."[2]

"When no type of occlusive pessary can be fitted, or when the woman refuses to use one, the only other reliable method is the use of the condom. With proper technic and instruction this method is highly reliable but has many disadvantages which the diaphragm method overcomes."[3]

1. Clinic Reports: Planned Parenthood Services in the United States. Human Fertility 10: 25 (Mar.) 1945.
2. Dickinson, R.L.: Techniques of Conception Control. Baltimore, Williams and Wilkins Co., 1942.
3. Warner, M.P.: J.A.M.A. 115: 279 (July 27) 1940.

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gynecological division

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Right on the Job . . .
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Neo-Synephrine minimizes the distressing nasal symptoms of common colds . . . permits patients to work more comfortably, sleep more restfully—even during the acute stages of coryza.

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For Nasal Decongestion

THERAPEUTIC APPRAISAL: Quick-acting, long-lasting . . . nasal decongestion without appreciable compensatory recongestion; virtually free from cardiac and central nervous system stimulation; consistently effective upon repeated use; no appreciable interference with ciliary activity; isotonic to avoid irritation.

INDICATED for symptomatic relief in common cold, sinusitis, and nasal manifestations of allergy.



ADMINISTRATION may be by dropper, spray or tampon, using the ¼% in saline or in Ringer's solution in most cases—the 1% in saline when a stronger solution is indicated. The ½% jelly in tubes is convenient for patients to carry.

SUPPLIED as ¼% and 1% in isotonic salt solution, and as ¼% in isotonic solution of three chlorides (Ringer's), bottles of 1 fl. oz.; ½% jelly in ⅜ oz. collapsible tubes with applicator.

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Regardless of the skill the Doctor incorporates in his ℞ it all can be undone with a poorly fitted pair of eye glasses.

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In the severe depressions of the menopause marked by apathy and psychomotor retardation

Many women in the climacteric period develop a true reactive depression, characterized by apathy, psychomotor retardation and despondency.

• This depressive syndrome is frequently progressive; and, unless promptly and effectively treated, may seriously impair the patient's normal capacity for useful living.

• In such cases, Benzedrine Sulfate helps to reawaken mental alertness and optimism, and to restore the savor and zest of life—especially when administered in conjunction with such fundamental measures as electric shock and estrogenic therapy.

• Obviously, Benzedrine Sulfate should not be used for the casual case of low spirits or normal physiologic depression, as distinguished from true prolonged mental depression. Smith, Kline & French Laboratories, Philadelphia, Pa.

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Tablets *Elixir*

(RACEMIC AMPHETAMINE SULFATE, S. K. F.)

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Similar to human milk



★The name is never abbreviated; and the product is not like any other infant food—notwithstanding a confusing similarity of names.

The fat of Similac has a physical and chemical composition that permits a fat retention comparable to that of breast milk fat (Holt, Tidwell & Kirk, Acta Pediatrica, Vol. XVI, 1933) . . . In Similac the proteins are rendered soluble to a point approximating the soluble proteins in human milk . . . Similac, like breast milk, has a consistently ZERO curd tension . . . The salt balance of Similac is strikingly like that of human milk (C. W. Martin, M. D., New York State Journal of Medicine, Sept. 1, 1932). *No other substitute resembles breast milk in all of these respects.*

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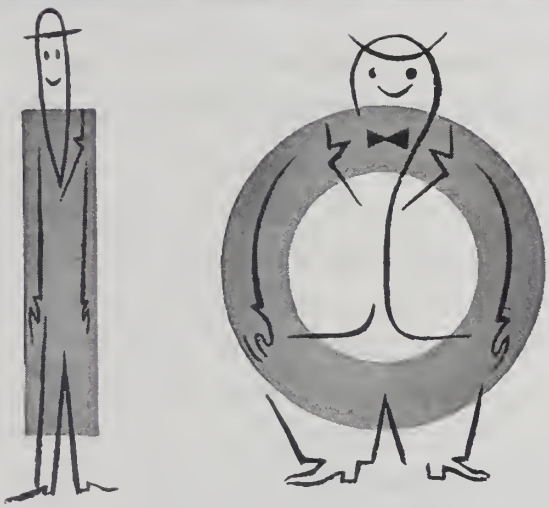
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a common denominator for all restricted diets



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1. Handbook of Nutrition. Chicago A. M. A., 1943, p. 557

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To the physician . . . and the patient . . . this means that control of menopausal symptoms can be *established* as well as maintained by tablet or liquid medication.

"PREMARIN" is well tolerated and essentially safe. Treatment is usually followed by a general feeling of well-being.

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Tablets of 1.25 mg. Tablets of 0.625 mg. Liquid, containing 0.625 mg. per teaspoonful

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A SAFE *Summer* PRESCRIPTION FOR INFANT NUTRITION

Even under the handicaps of travel or vacation accommodations, a mother can easily prepare a *safe* formula for her infant . . . by just adding cooled boiled water to Biolac according to the physician's directions. The simplicity of preparation (dilution only) minimizes possibilities of formula contamination even under adverse conditions.

In addition to safety and simplicity of preparation, Biolac formulas provide complete nutrition when supplemented with vitamin C. No chance omission of needed vitamins, carbohydrates or iron can occur. Biolac simply and safely affords nutritional elements for optimum health.

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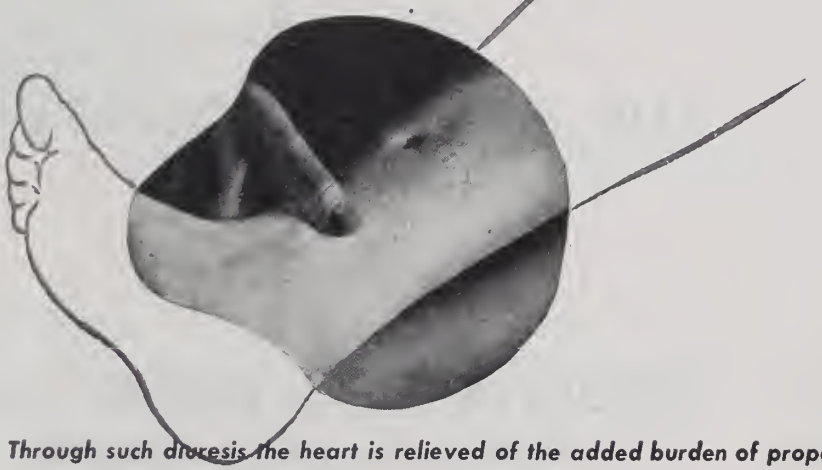
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NEXT IN IMPORTANCE TO DIGITALIS

In many cases of congestive heart failure mercurial diuretics are next in importance to digitalis in maintaining the patient's comfort and prolonging life.

Following an injection of Salyrgan-Theophylline in patients with marked edema the urinary output frequently amounts to three or four liters in twenty-four hours.



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Salyrgan-Theophylline is available in ampuls of 1 cc. and 2 cc. for intramuscular or intravenous administration . . . For oral use (as an adjunct to decrease the frequency of injections and when parenteral therapy is impracticable) tablets in bottles of 25, 100 and 500.

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Often the cause of unexplained symptoms and signs arising from the urinary tract may be read like an open book when x-ray contrast is obtained with

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U R O G R A P H Y

Neo-Iopax, injected by the intravenous or retrograde route, produces images as sharp as clear print. Because of its safety and versatility it may be used whenever pyelography and cystography are indicated.

Neo-Iopax, disodium N-methyl-3,5-diiodo-chelidamate, is supplied as a stable, crystal clear solution in 50 per cent and 75 per cent concentrations.

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Many physicians prefer Acidophilus when prescribing a Lactic formula for infant feeding. It has several important advantages.

1. Acidophilus is the only sour milk organism that will live and grow in the intestinal tract.
2. It has a count at time of bottling of over 500,000,000 highly active L. acidophilus organisms of human origin.
3. It is prepared from Walker-Gordon Certified Milk (2% butterfat) and any higher percent of fat may be obtained on prescription.
4. Clinical tests have demonstrated the therapeutic value of Acidophilus Milk in the treatment of constipation of infants and children.*

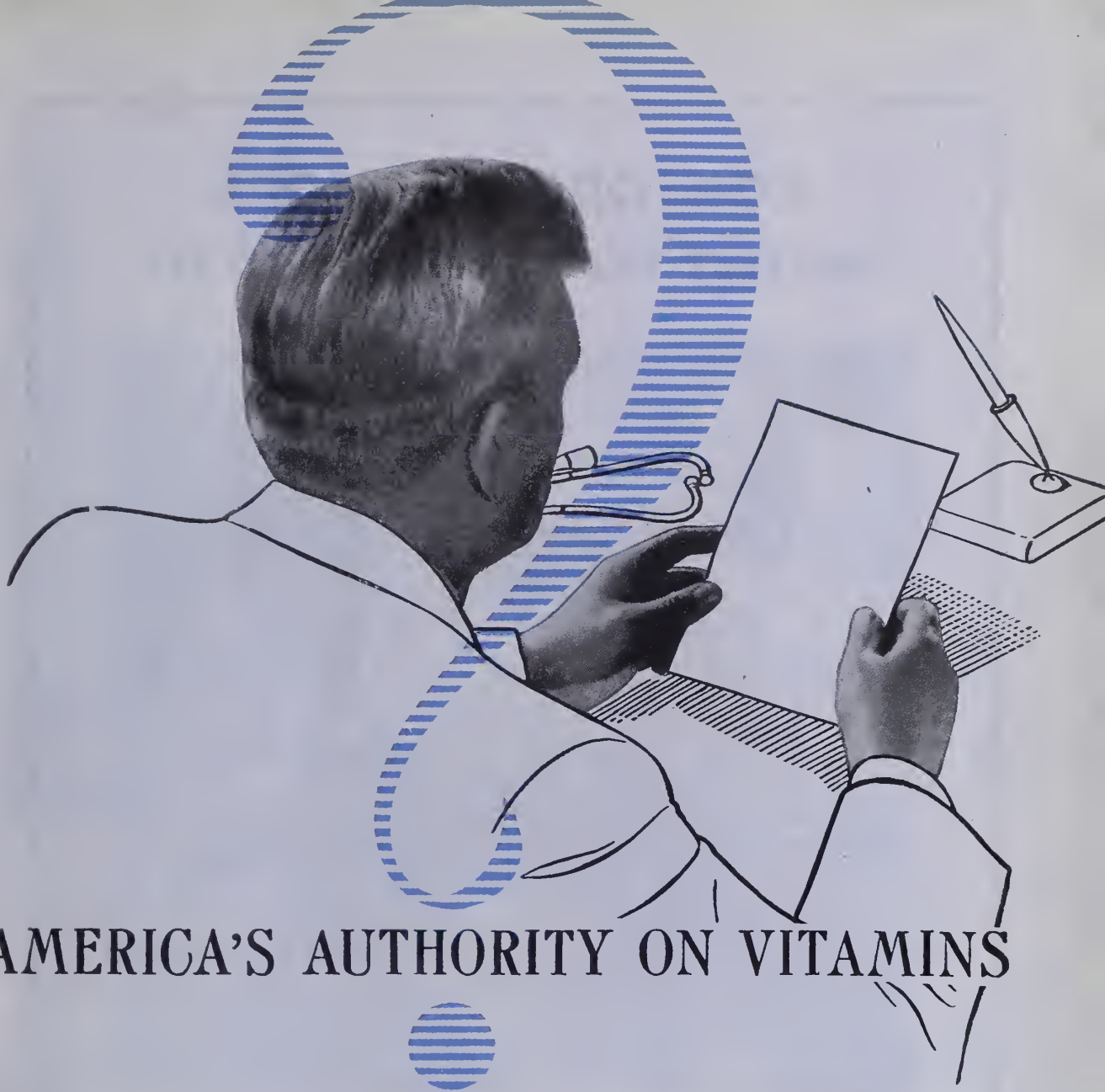
We believe that it is impossible to buy a more effective Acidophilus—anywhere

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Acidophilus

***(For information on clinical tests with Walker-Gordon Acidophilus, write to Walker-Gordon Laboratories, Plainsboro, New Jersey.)**

Phone the nearest Borden brand, or call Plainsboro 2750.



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Who is he? The American physician. It is he who is *qualified* to diagnose vitamin deficiency disease, to treat or prevent it with suitable amounts of the indicated vitamins.

Therefore, to the end that White's vitamin products may contribute most effectively to American well being, information concerning these preparations, like all White's pharmaceuticals, is entrusted to the profession alone.

Our promotion does not deviate from the *strictly* ethical.

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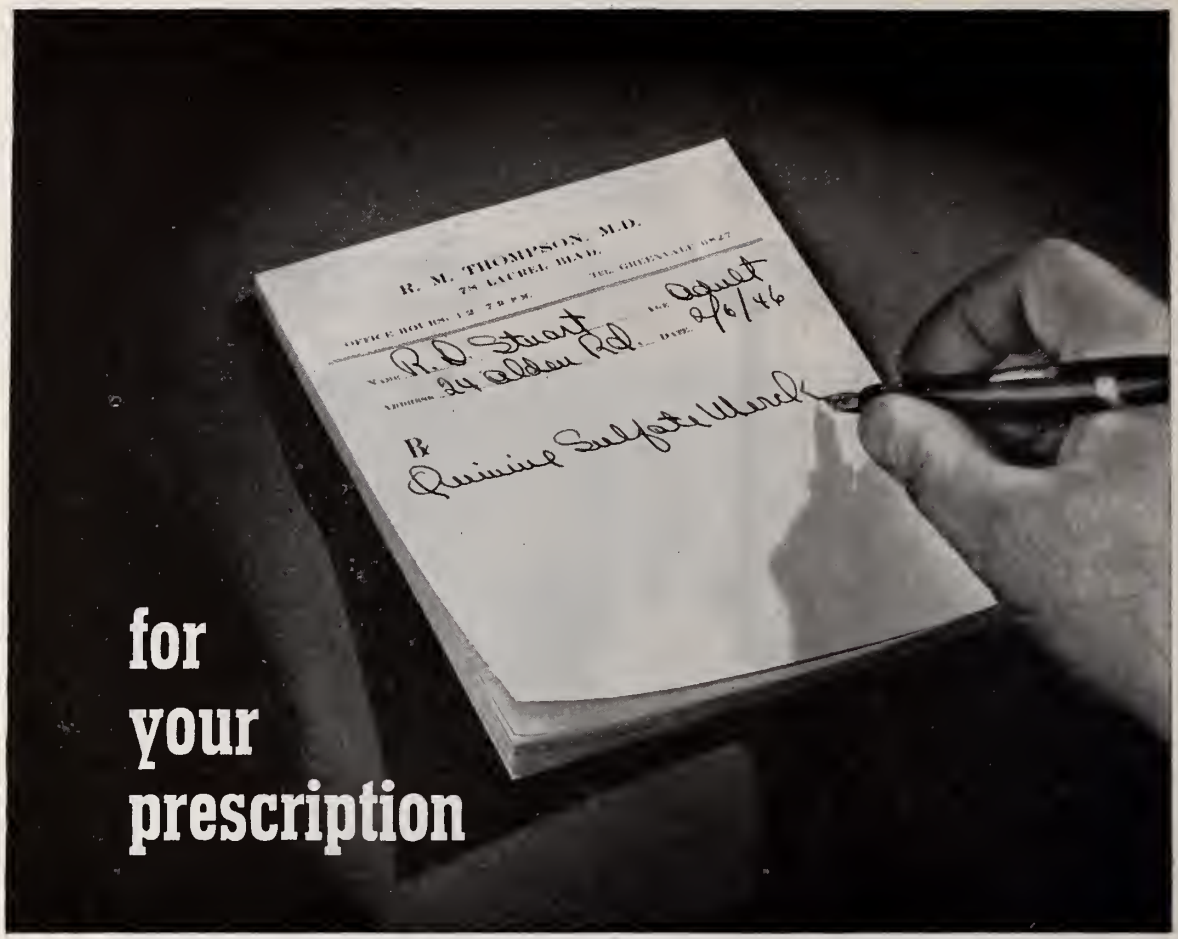
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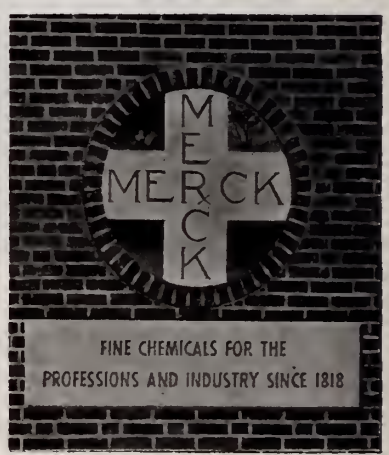


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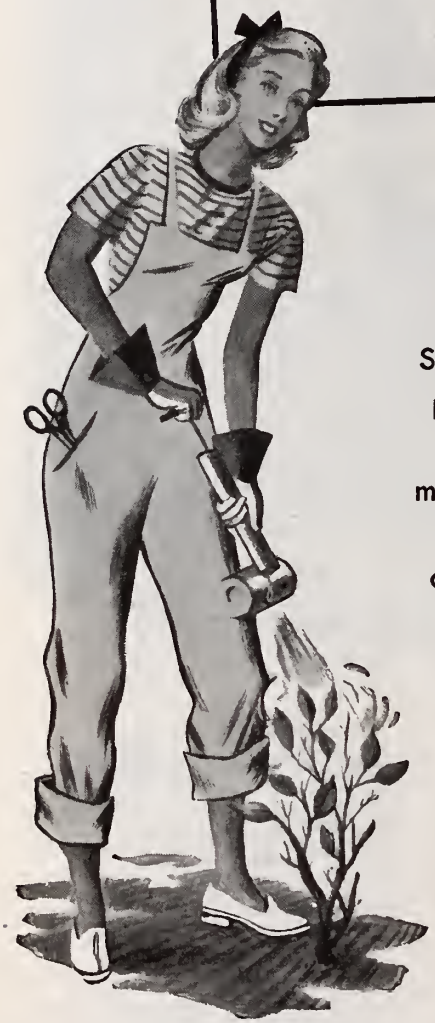
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Volume 43
Number 6

THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Published Monthly Since September, 1904
Whole Number of Issues, 502

Under the
Direction of the
Committee on Publication

Henry C. Barkhorn, M.D., Chairman

Henry A. Davidson, M.D., Editor

Place of Publication, Printing and Mailing—12 South Day Street, Orange, N. J.
Editorial and Executive Offices of the Society—315 West State Street, Trenton 8, N. J.; Tel. 5776
Send all communications to the Trenton Office.
Each member of the State Society is entitled to receive a copy of The Journal every month.

Vol. 43, No. 6 June, 1946 Subscriptions, $3.00 per Year
Single Copies, 30 Cents

INTRODUCING DR. SCAMMELL

Leader of The Medical Society of New Jersey this year is Dr. Frank George Scammell, Trenton surgeon. Dr. Scammell was born in Trenton in 1877 and was graduated from the Medico-Chirurgical College of Philadelphia (now the Graduate School of the University) in 1899. After an internship and brief practice in his home town, he returned to Philadelphia in 1905 for graduate study of gastro-enterology. During the following two decades he practiced medicine and surgery in Trenton and in 1927 went to Great Britain to do advanced work in abdominal and gynecologic surgery. There he studied and operated at the medical school of the University of Liverpool, at the Faculty of Medicine in Edinburgh and in the London Hospital Medical College.

Dr. Scammell is visiting surgeon to the Mercer Hospital, and consulting surgeon to the Orthopedic and New Jersey State Hospitals in Trenton. He is a past president of the Mercer County Medical Society, of the Society of Surgeons of New Jersey and of the Medical Staff of Mercer Hospital.



In spite of a busy practice, Dr. Scammell never neglected his civic duties. He served for eight years as City Physician, relinquishing that post in 1908 to become County Physician. At the occasion of his

resignation as County Physician in 1923, the *Trenton Times* made the following comment about the man who now heads our Medical Society:

"Dr. Scammell refutes the old saying that none resign from public office by announcing to the Freeholders his intention of retiring at the close of his present term. His action is all the more surprising in view of the fact that he has had no opposition for re-election. Had he been less conscientious about his duty to the public he might easily have secured another term and gone on drawing $2,500 yearly from the County with little or no serious interference with his private practice and other personal interests. It is to the doctor's credit, however, that he is unwilling to do what so many others would do, take pay of a public official and work in the duties as a side line, giving them as little attention as possible. Dr. Scammell has served the County well for some fifteen years, and before that he acted in a similar capacity for the City. His record in public life has been of the best. It is too bad that men of his type cannot have the time to fill public office. It is the man who is successful and proficient in private affairs who does the best work in public position."

Even this combination of civic interests and surgical practice did not exhaust Dr. Scammell's activities. He was always active in Masonic affairs and carried on extensive business interests in connection with the Scammell China Company, of which organization he is secretary.

Dr. Scammell has had distinguished civilian medical service during both wars. He was examining surgeon for rural Mercer County in 1917 and 1918 and Chairman of the County Selective Service Board during the recent war.

The Society anticipates an energetic, progressive administration.

THE DILEMMA OF SPECIALIZATION

"Medicine is caught on the horns of a dilemma which its own progress has forced upon it. The more the healer knows about the patient's disease, the easier it is for him to lose touch with the patient. It would be unwise to check the growth of specialized knowledge. No short-cut to the integration of specialized knowledge into comprehensive medical care has yet been devised. But until this problem is solved, medicine will be inadequate."

So writes the compiler of the recently released annual report of The Commonwealth Fund. The report states the problem, but cautiously advances no answer.

So many demobilized doctors have indicated a desire to enter a specialty that an observer would conclude that the general practitioner is indeed a vanishing American. Perhaps the time will come when all M.D.'s will be specialists and the patient himself will have to decide whether his headache falls under the jurisdiction of the ophthalmologist, the internist or the psychiatrist. And when that time comes, medicine will fall on evil days. It may be said that the bugaboo is a mere fantasy, that requiems have been sung over the G.P. often before, and that he is still articulate, numerous and flourishing. But it is not so simple. Most medical students today have announced that they want to enter some specialty. Hospitals all over the country are trying to make more provisions for residency training. With Uncle Sam playing the role of Santa Claus to educational institutions that admit veterans, resources for graduate medical education are rapidly expanding. The American Boards labor with ever-increasing tempo. Huge machinery for the training and certification of specialists is still unable to cope with

the demand; but facilities are expanding and agencies do not let their machinery rust in idleness.

During the next decade we will see a sky-rocketing increase in the proportion of specialists in America's medical roster. Hospitals which have established residencies will not lightly abandon them; graduate schools which have enjoyed boom times will not willingly reduce their student bodies.

Every doctor recognizes that this is unhealthy. Each of us sings the glories of general practice. But always, of course, for the other fellow. Perhaps in the long run, the inexorable law of supply and demand will put some brakes on the specialist-manufacturing machinery. But in the meantime there will be a rapidly shrinking pool from which to recruit general practitioners. Two solutions have been proposed. One is a more or less arbitrary quota system for specialists, an arrangement whereby the American Boards, the graduate schools and the hospitals would say, perhaps: We shall create only so many proctologists or only so many pediatricians this year. The other, a campaign to make general practice more attractive. The first method is efficient but distasteful. If, for example, it is agreed that only twenty residencies in ophthalmology or twenty courses in allergy will be made available this year, what happens to the 21st applicant—who might be exceptionally well qualified or brilliantly heated up with a passionate desire to be a specialist? And a system of specialist birth control by fiat seems undemocratic and subject to abuse.

An affirmative approach seems more in line with the American tradition. But how to make general practice more attractive? Larger fees, certification for G.P.s, an assistant for every practitioner, a section on general practice in our medical societies? We cannot tell until we know what's wrong with general practice. Does anyone have the answer to that one?

PUBLIC HEALTH WEEK IN MERCER

A capital job by our capital county must be the verdict on Mercer County's Public Health Week. During the week of May 13, the Mercer County Medical Society embarked on a program designed to enlighten the public on medical progress and win community support for public health measures. The program was well thought out, smoothly administered and conspicuously effective. Members of the Mercer County Medical Society addressed civic organizations; seminars were held with affiliated health professions, editorials appeared in the Trenton *Times* and talks were broadcast over the local radio station. To the public it was an interesting and instructive week which provided them with more health information, earned more good will for the medical profession, and stimulated more health consciousness than anything that has happened in years. To the Mercer County Medical Society it was an earnest token of how seriously organized medicine is taking its responsibility for communal activity and public education. The Public Relations Committee of the Mercer County Medical Society has earned the plaudits of the profession for this practical demonstration in building community good will. Since Dr. Blaugrund, Chairman of Mercer County's Public Relations Committee, is now Chairman of our State Society's Public Health Committee, we look forward to an extension to the state level of this kind of vigorous civic leadership. Public Health Week for Mercer County has been so successful, that the profession now asks, "Why not a Public Health Week for all New Jersey?"

ORIGINAL ARTICLES

CLINICAL USES OF THE VARIOUS INSULINS

BENJAMIN SASLOW, M.D., Newark, N. J.

Administration of insulin is a perfect example of substitution therapy whereby deficient secretion of the Islands of Langerhans is artificially compensated. Insulin provides chiefly for the utilization of carbohydrate absorbed from the intestinal tract and dextrose which enters the circulation from the liver.[1] Dosage of insulin depends upon two main factors: (1) Degree of insulin deficiency in the pancreas. (2) Intensity of mechanisms opposed to insulin. Among the latter may be mentioned: (a) Rate of supply of dextrose from food; (b) effect of endocrins antagonistic to insulin, such as the pituitary, adrenals and thyroid; (c) effect of infections; (d) presence of recent or coincident acidosis; (e) abnormalities of liver function; (f) variations in irritability of the autonomic nervous systems, and (g) presence of insulin-sensitivity or insulin-resistance.

UNMODIFIED INSULIN

Insulin is an amorphous protein soluble in water when prepared as a hydrochlorid. Zinc salts of insulin are crystalline in nature and are commercially available under the name of "solution of insulin crystals". Because of its greater chemical purity the latter variety is especially indicated for patients who exhibit allergic reactions to amorphous insulin.

The consensus is that insulin of amorphous origin may ordinarily be interchanged with the variety prepared from zinc insulin crystals and differs inconspicuously from it in activity. In this paper the term *unmodified or regular insulin* will refer either to the amorphous or the crystalline variety.

In the practical clinical consideration of any insulin three properties are important, viz.: (1) initial effect, (2) maximum effect, and (3) completion of effect.

The hypoglycemic effect of unmodified insulin begins one to two hours after injection, exerts its maximum effect in two to four hours and is completely spent in four to six hours. This type of insulin should be employed where rapid or powerful action is desired and is especially indicated in emergencies, acute complications or where insulin requirements fluctuate rapidly. In severe cases, fasting blood sugar levels treated with regular insulin are characteristically elevated but fall during the day if insulin is injected prior to meals.

PROTAMIN ZINC INSULIN

Protamin zinc insulin, first made available in 1937, is a combination of insulin, protamin and zinc. Protamin is a relatively non-antigenic polypeptide obtained from the sperm of rainbow trout or salmon. Zinc which is added to the amount of 1 mg. per 500 units stabilizes the protamin-insulin combination, slows its absorption and prolongs its effect. This metal is present in too small an amount to exert toxic action. Recent experiments [2] with radio-active zinc have shown that practically all of it is excreted in the pancreatic juice and from the duodenal mucosa.

Protamin zinc insulin is almost insoluble at the pH of body fluids and thus absorption is delayed, activity prolonged and insulin released at a constant rate for a period of one to three days from a single injection site. Initial effect begins in two to three hours and maximum action occurs in 18 to 24 hours. When protamin zinc insulin acts longer than one day, it is important to remember that the final effect of one day's dose may be superimposed upon the first effect of the dose given the following day.

Advantages of this insulin over the unmodified type are: the number of multiple injections is reduced, glycosuria and hyperglycemia

1. Wilder, R. M.: Clinical Diabetes and Hyperinsulinism. 1940, W. B. Saunders Co., Philadelphia, p. 81.
2. Montgomery, M. L.; Sheline, G. E., and Chaikoff, I. L.: J. Exper. Med., 78:151 (Sept.) 1943.

are usually better controlled, violent insulin reactions are infrequent, less rigid control of the dietary factor is necessary, unphysiologic undulations of blood sugar levels occur less often and the decreased azoturia and ketonuria probably represent better sparing of tissue proteins.

Ricketts [3] first demonstrated that the hypoglycemic effect of protamin zinc insulin is constant, regular and inexorable and that its effect is chiefly upon endogenous carbohydrate metabolism while unmodified insulin exerts its action chiefly upon exogenous glucose.

Because of its slow and prolonged action, protamin zinc insulin should be regarded as basic in most cases; but by the same token it predisposes to post-prandial hyperglycemia and glycosuria.

In patients responding adequately to protamin zinc insulin, blood sugar before breakfast is normal and, except in very mild cases, ascends during the day because active insulin is released too slowly to overcome the hyperglycemic effects of food.

Generally speaking, patients who have relatively mild cases, and whose requirements range between 30 to 40 units per day, do well with a single daily dose. It is most commonly given before or after breakfast but ordinarily it does not matter much what time is chosen *providing that this time is regularly maintained* and the arrangement of the meals is optimum and not altered.

Severe or moderate diabetes cannot be controlled with a single daily injection of protamin zinc insulin even when a relatively large night feeding is employed to prevent nocturnal hypoglycemia. This problem has been met in a satisfactory manner in many instances by giving a large dose of protamin zinc insulin and a smaller dose of regular insulin both before breakfast. Occasionally an accessory dose of regular insulin must be added before or after lunch or dinner. Thus the prolonged activity of protamin zinc insulin is utilized to prevent nocturnal hyperglycemia while the unmodified insulin tends to combat the rise of the blood sugar after meals. However, in many cases even this methods fails to regulate the patient.

Combined therapy is not new. Analogies in other branches of medicine are the combinations of avertin and ethylene, ouabain and digitalis and dicumerol and heparin.

Two commonly overlooked symptoms of protamin zinc insulin reaction are morning headache and a feeling of exhaustion.

INSULIN MIXTURES

Although combined insulin therapy is a great improvement over the use of either type alone in moderate or severe cases, there are some valid objections to it, viz.:

a. It is a compromise method requiring more than one daily injection and thus one of the chief advantages of protamin zinc insulin is nullified.

b. Manipulation by the patient of two types of insulin increases the possibility of error and also makes the management of the disease more burdensome to him.

The term "insulin mixture" implies the mixture of various proportions of unmodified and protamin zinc insulin either in the syringe just before injection or in an insulin bottle which is then used for subsequent injections.

Protamin zinc insulin contains an excess of about 40 per cent protamin. This varies with different manufacturers. When a small quantity of unmodified insulin is mixed with a larger amount of the protamin zinc variety, the mixture assumes activity indigenous only to the latter type. This is because the unmodified insulin is converted wholly into the protamin zinc variety by the excess protamin present. For example, a mixture of 45 unts of protamin zinc insulin and 10 units of unmodified insulin will produce 55 units of protamin zinc insulin.

However, as a greater proportion of regular insulin is added, the resulting mixture tends more and more to assume quick acting qualities.

Purpose of these mixtures is to combine in one injection the good features of each type and to attempt to create a preparation tailormade for the individual or greatest number of cases. However, there is no unanimity of opinion as to what constitutes the best mixture. An examination of current literature discloses the folowing: MacBryde [4] states that equal

3. Ricketts, H. T.: Constancy of Action of Protamin Zinc Insulin. Am. J. of Med. Sci., 201:51 (Jan.) 1941.
4. MacBryde, C. M., and Roberts, H. K.: Modified Protamin Zinc Insulin. J. A. M. A., 122:1225 (Aug. 28) 1943.

parts of the two insulins are optimum. Colwell and Izzo[5] favor two parts of regular to one part of protamin zinc insulin. Ulrich[6] says the ideal solution is in three-to-two proportion while Hildebrand and Rynearson[7] recommend mixtures of one to one up to five to one, and also speak favorably of three to two and five to two proportions.

Confusingly enough the latter authors find that equal mixtures of the two insulins give only protamin zinc effects while MacBryde[4] states that this produces a large unmodified insulin effect. Each seems to assume that his pet mixture has acquired vital activity, and is the best one; and when injected chooses to act selectively to release insulin at the exact time and amounts as need arises.

At the last meeting of the American Diabetes Association, a poll disclosed that mixtures ranging from five parts of unmodified to one part of protamin zinc insulin and vice versa were being used by its members. This speaks for itself. The Association tabled any recommendation of specific insulin mixtures.

While mixtures have been described as effective in many cases, I am not prepared to accept wholly all the laudatory reports. With so many variable factors constantly to be considered in this disease: dietary, exercise, metabolic, endocrine, etc., it seems to me to be unwise to introduce yet another variable. It complicates matters both for the patient and the doctor.

I have had but little experience with mixtures and have used a one to one combination in twelve cases. I have been neither favorably nor unfavorably impressed.

Joslin[8] employs such mixtures infrequently and sums up his idea about them by a quotation from Hamlet: We prefer to "bear those ills we have than to fly to others we know not of."

5. Colwell, A. R., and Izzo, J. L.: Protamin Zinc Insulin Modified for Accelerated Action. J. A. M. A., 122:1231 (Aug. 28) 1943.

6. Ulrich, H.: Clinical Experiments with Mixtures of Standard and Protamin Zinc Insulins. Ann. Int. Med., 14: 1166 (Jan.) 1941.

7. Hildebrand, A. G., and Rynearson, E. H.: Clinical Experience with Mixtures of Protamin Zinc and Unmodified Insulins. Arch. Int. Med., 72:37 (July) 1943.

8. Joslin, E. P.: Management of Diabetes in General Practice. Med. Clin. of N. Am., p. 1055 (Sept.) 1944.

9. Personal Communication from D. S. Searle of the Burroughs Wellcome Company.

GLOBIN INSULIN

Globin insulin is a new tool in the treatment of diabetes. It is an artificial chemical combination of ordinary insulin, zinc and globin prepared at a pH of 3.4 and is water-clear. Globin is a weakly antigenic protein and is obtained from the hemoglobin of beef blood. It exerts its initial effect two to three hours after injection and maximum action occurs eight to twelve hours later. Thus it lies somewhere between unmodified and protamin zinc insulin in activity. When given once a day it is customarily injected before breakfast and thus maximum effective action occurs when the meals are being eaten and the patient is active and awake. During the night, its action wanes and this is particularly desirable as the effects may occasionally carry over beyond twelve to eighteen hours. I have had one patient who had a severe reaction during the night after a morning dose.

Occasionally protamin zinc insulin with or without unmodified insulin will seem to exert very little effect on a fasting high blood sugar. When globin insulin under such circumstances is given twice a day, before breakfast and before supper, this will often take place. When a fasting blood sugar is maintained at a normal level with protamin zinc insulin, switching to globin insulin once a day has been generally unwise. Blood sugar under such circumstances often rises.

Globin insulin will generally clear up local allergic reactions in patients on protamin zinc insulin. I have had three such experiences. Almost 20 per cent of patients receiving this insulin complained of a severe burning sensation during or after injection. This is said to have been corrected by the addition recently of 1.5 per cent glycerine to the commercial product.[9]

Unit per unit, globin insulin seems to be more effective than either regular or protamin zinc insulin. When I first began to use it I frequently gave too large a dose when transferring patients from protamin zinc insulin. It is wise not to give more than half the dose of protamin zinc insulin initially when making this transfer and even smaller doses are judicious when the patient is unreliable as to diet.

This insulin should not be used initially in infections, acidosis, pregnancy or diabetic surgery because of its unpredictability as to the time and extent of hypoglycemia.

The arrangement of the carbohydrates in the meals is particularly important when globin insulin is used and experience has taught us that if sufficient carbohydrate is not available when it begins to exert its effect, the blood sugar may fall precipitiously and induce severe symptoms.

The carbohydrate portion of the meals should be highest at noon to buffer its effect and it is best to add a small carbohydrate feeding about 3 p. m. However, each case must be individualized and no rule can be given for the number of units required or arrangement of the meals. Chief difficulty with this type of insulin seems to be the sudden onset of severe insulin reactions unheralded by the usual premonitory symptoms and signs. Three of my patients lapsed suddenly into unconsciousness. One of them had this experience while driving a car and subsequently was arrested for drunken driving. These hypoglycemic effects may occur even when anticipatory carbohydrates have been given and shock symptoms and their times of occurrence change not infrequently without cause.

Most insulin reactions occur in the late afternoon but I have seen reactions in the forenoon, during the evening hours and even during the night.

Others in this state have had similar experiences, and if it is so frequently explosive in the hands of those who see many diabetic patients, it cannot be recommended without reservation to those who treat the infrequent case.

CONCLUSIONS

A short resume of unmodified, crystalline, protamin zinc and globin insulin has been presented. Combinations of unmodified and protamin zinc insulin by multiple injections or in mixtures have been described.

Basic use of protamin zinc insulin with or without unmodified insulin by multiple injections has been found to be most satisfactory.

Insulin mixtures are promising but require more study and unification before they can be recommended.

Globin insulin, although helpful in difficult cases, is not generally recommended because of its tendency to produce severe and unpredictable insulin reactions.

TUBERCULOSIS AND ORGANIZED MEDICINE

"Whatever success has been thus far achieved in controlling tuberculosis is a direct contribution of organized medicine to the welfare of the human race. Critical and querulous comment is rather too commonly heard, charging the medical profession with dereliction of its duty in not suspecting and therefore discovering tuberculosis in its earliest or minimal stage. This criticism is largely unfair, since it is only through the x-ray that the disease can be discovered thus early. Although the x-ray has been in use for a good many years, facilities for its adequate application have only recently been generally distributed. From now on it will take the place it deserves as our outstanding diagnostic medium and be used without limitation by internists everywhere." — Kendall Emerson, M.D., in the *Hoosier Health Herald,* 1946.

HAS THE NUMBER OF ANNUAL BIRTHS IN THE UNITED STATES PASSED ITS PEAK?

"Probably. It is estimated that in 1921 there were more than 2,600,000 births in the United States. This was the year in which the post-war boom in the birth rate occurred. After that there was an almost continuous decline to the year 1933, when the number of births was 2,081,232, the lowest figure since the peak year, 1921. After that, the number moved somewhat irregularly up and down with, on the whole, an upward tendency, leading to the 1940 figure of 2,353,988, the highest since 1928. It remains to be seen whether the upward movement will continue to a new all-time high. This would require an increase of about one-quarter of a million over last year's figure to match the number of births estimated for 1921."—Statistical Bulletin of the Metropolitan Life Insurance Co.

EFFECT OF HESPERIDIN AND ASCORBIC ACID ON CAPILLARY FRAGILITY IN RHEUMATOID ARTHRITIS

A PRELIMINARY REPORT

PETER J. WARTER, M.D., Trenton, N. J.
HENRY L. DREZNER, M.D., Trenton, N. J.
STEVEN HOROSCHAK, B.S., Ridley Park, Pa.

Abnormal capillary fragility is frequently observed in rheumatoid arthritis. This may be manifested in the form of ecchymotic areas, appearing either spontaneously or as the result of slight traumatism.

Although the etiologic factor in rheumatoid arthritis has not been definitely established, such findings as leukocytosis, increased sedimentation rate, and inflammation of synovial membrane and periarticular tissue strongly suggest an infective basis.

CAUSATIVE FACTORS IN CAPILLARY FRAGILITY

Warter et al.[1] suggested bacterial toxins or other toxic agents as contributing etiologic factors in rheumatoid arthritis. Since bacterial toxins or other injurious agents may seriously damage capillary walls, the permeability and fragility of the capillaries may be affected.

Vitamin C avitaminosis has been reported as a possible causative factor in capillary fragility. Greene [2] and Perry,[3] however, have pointed out that a positive reaction to a capillary resistance test does not necessarily denote C avitaminosis. Liebman et al.[4] noted little agreement between plasma vitamin C and tourniquet tests in capillary fragility. Rappaport et al.[5] find that "abnormal (positive) capillary fragility test does not necessarily denote a state of C avitaminosis, nor does a normal capillary fragility test signify adequacy of C in the blood."

PURPOSE OF INVESTIGATION

The successful clinical treatment of hemorrhagic purpura and other disorders, arising from abnormal capillary fragility, by the administraton of hesperidin (vitamin P), has been reported by a number of investigators.[6, 7, 8, 9] Clinical and pharmacologic studies indicate the value of hesperidin (vitamin P) in controlling the condition of the capillaries in many kinds of cases. We, accordingly, decided to evaluate the benefits of hesperidin (vitamin P), plain ascorbic acid (vitamin C) and hesperidin combined with ascorbic acid in patients with rheumatoid arthritis showing abnormal capillary fragility.

PREPARATIONS USED

Hesperidin (vitamin P) is a flavanone glucoside occurring in most varieties of citrus fruits. Pure hesperidin occurs in long hair-like colorless needles, readily soluble in alkali and only sparingly soluble in water. Hesperidin, in common with other flavanone glucosides, has the property of forming complex crystals with similar glucosides, which greatly affect its solubility and other physical properties, making it difficult to obtain it in a pure state. Whether hesperidin itself is actually vitamin P, or whether it is merely a precursor which forms the vitamin in the digestive system is not yet known.

The hesperidin for this investigation was supplied * as a 100 mg. compressed tablet.

Ascorbic acid (vitamin C), U. S. P., occurs as a white, odorless crystalline powder, freely

1. Warter, P. J.; Donio, D. A.; Horoscbak, S.: Combined Antigen in Treatment of Rbeumatoid Artbritis. J. Med. Soc. N. J. 42: 391 (Dec.) 1945.
2. Greene, D.: Evaluation of Capillary Resistance in Subclinical Scurvy. J. A. M. A. 103: 4 (July 7) 1934.
3. Perry, C. B.: Rbeumatic Heart Disease and Vitamin C. Lancet 2: 426 (Aug.) 1935.
4. Liebman, J.: Wortis, H., and Wortis, E.: Capillary Fragility and Vitamin C Content. Amer. Journ. Med. Sci. 196: 389 (Sept.) 1936.
5. Rappaport, H. G.; Miller, S. H., and Sicular, A.: Capillary Fragility and Ascorbic Acid. Journ. Ped. 16: 624 (May) 1940.
6. Armentano, L.; Bentsath, A.; Beres, T.; Rusznyak, I., and Szent-Gyorgyi, A.: The Effect of Substances of the Flavone Group on Capillary Permeability. Deut. med. Wocbschr. 62: 1326 (Aug.) 1936.
7. Scarborough, H., and Stewart, C. P.: Effect of Hesperidin on Capillary Fragility. Lancet 2: 610 (Sept. 10) 1938.
8. Rinehart, J. F.: The Treatment of Rheumatic Fever with Vitamin P. Calif. Health 1: 163 (May 31) 1944.
9. Griffitb, J. Q., Jr., and Lindauer, M. A.: Increased Capillary Fragility in Hypertension. Amer. Heart Journ. 28: 758 (Dec.) 1944.

* By the National Drug Co. of Philadelphia.

soluble in water. Among the richest natural sources of ascorbic acid are the citrus fruits, tomatoes and green peppers. The human requirements of ascorbic acid are not definitely known. The deficiency phenomena have been explained as inability of the mesenchymal supporting tissues to form and maintain their characteristic intercellular substance. The defect is said to involve collagen of all non-epithelial cement substance, including that of the vascular endothelium.

The ascorbic acid for this investigation was supplied * as a 100 mg. compressed tablet.

Hesperidin (vitamin P) — Ascorbic Acid (vitamin C): Inasmuch as vitamin P is associated with vitamin C in nature, it appeared desirable that these two vitamins should be combined for therapeutic purposes. Furthermore, it has been suggested that vitamin P is efficient for the absorption and retention of ascorbic acid.

Rinehart [8] reported that vitamin C and vitamin P are of value in rheumatic fever. He concluded: "If nutritional deficiencies of vitamin C and vitamin P prove to be conditioning factors 'which prepare the soil' for rheumatic fever, the prophylactic implications are clear." Goldfarb [10] obtained better results with vitamin P and vitamin C in the treatment of psoriasis than with vitamin P alone.

The natural occurrence of these two vitamins together and the clinically demonstrated supplementary nature of their actions would tend to indicate their efficacy in capillary fragility.

The Hesperidin and Ascorbic Acid combination was supplied * as Hesperidin-C in a compressed tablet containing 50 mg. each of hesperidin and ascorbic acid.

PROCEDURE

Twenty patients with rheumatoid arthritis (average: 8.3 years' duration) were selected for this investigation. Most of these patients exhibited, at times, ecchymotic areas suggesting the possibility of abnormal capillary fragility. This was confirmed by the cuff pressure test. The sphygomomanometer cuff is applied above the elbow and pressure raised to a level half way between the systolic and diastolic pressures. This is maintained for fifteen minutes, after which the pressure is released and the cuff removed. A lapse of five minutes is allowed before a count of the petechae is made. The petechae appear in each of two horizontal circles (about 2.5 cm.), located about 4 cm. below the antecubital fossa. An average of ten or less was considered normal; ten to twenty, borderline; twenty or more as evidence of abnormal (positive) capillary fragility. (Wright and Lilienfeld.[11])

Following the plasma vitamin C determinations and capillary fragilty tests, the twenty patients were divided into three groups.

Group A: Five patients, four females and one male, were selected for this group. The latter showed an apparent normal capillary fragility with a plasma vitamin C content of 1.03 mg. per 100 cc. plasma. Capillary fragility in the female patients ranged from 38 to an average too numerous to determine. Plasma vitamin C varied from 0.54 mg. to 1.94 mg. per 100 cc. plasma.

The patients in this group were given hesperidin (vitamin P), 100 mg. twice daily; one tablet after breakfast and one tablet at bedtime. A plasma vitamin C determination and a capillary fragility test were made four weeks later and at monthly intervals in most of the patients.

Group B: Four patients, three females and one male, were selected for this group. All showed a positive capillary fragility, ranging from 25 to 39 petechae. The plasma vitamin C varied from 0.62 mg. per 100 cc. plasma to 1.25 mg. per 100 cc. plasma.

These patients were given ascorbic acid (vitamin C) 100 mg. twice daily; one tablet after breakfast and one tablet at bedtime. The same procedure of laboratory and clinical studies was followed with these patients as with those in group A.

Group C: Eleven patients, one male and ten females, were selected for this group. Six of the female patients showed a very markedly positive capillary fragility, the petechae being too numerous to count. Four showed a petechae count varying from 28 to 36. The plasma

10.* Goldfarb, A. E.: Treatment of Psoriasis with Lemon Citrin (Vitamin P) and Ascorbic Acid. Arch. Derm. & Syph. 43: 536 (March) 1941.

vitamin C determinations ranged from 0.28 mg. to 2.17 mg. per 100 cc. plasma.

These patients were given tablets of Hesperidin-C, a combination of hesperidin 50 mg. and ascorbic acid 50 mg. in each tablet. These were administered twice daily, one tablet after breakfast and one tablet at bedtime.

CLINICAL RESULTS

We observed no correlation between capillary fragility, as manifested by the cuff pressure test, and plasma vitamin C findings. Our observations confirm those reported by Greene,[2] Perry,[3] Liebman et al.,[4] and Rappaport et al.[5] A number of the patients showed a high plasma vitamin C content and a very pronounced abnormal capillary fragility. Several patients with slightly over borderline capillary fragility showed the lowest plasma vitamin C values.

Group A: Hesperidin (vitamin P). One patient, after two months, showed improvement from pronounced abnormal fragility to a borderline status. One patient with marked abnormal fragility showed conspicuous improvement, then discontinued the hesperidin for two weeks with a resultant increase in capillary fragility. Two patients were only moderately improved, and one showed a fragility which remained normal throughout the investigation. The plasma vitamin C values in all patients were lower after two months' treatment.

Group B: Ascorbic Acid (vitamin C). One patient with a moderately abnormal capillary fragility showed a negative fragility after two months of treatment although the plasma vitamin C value was slightly lower than originally. Three patients showed very little or no improvement in capillary fragility after four months of treatment, although plasma vitamin C values were increased.

Group C: Hesperidin-C (vitamin P and vitamin C). Two patients in this group with a moderate abnormal capillary fragility became normal after one month of treatment. Six patients with originally pronounced abnormal fragility (the test areas were showered with petechae), improved considerably in that three became borderline and showed a decrease in plasma vitamin C values after four months; three showed litle change in plasma vitamin C values but the capillary fragility was considerably improved. The three remaining patients showed borderline fragility on original cuff pressure tests and approximately the same plasma vitamin C values. After four months of treatment there were no appreciable changes in the capillary fragility or plasma vitamin C.

SUMMARY AND CONCLUSIONS

Twenty patients with rheumatoid arthritis, most of whom presented indications of possible capillary fragility were studied. These patients were divided into three groups. Patients in group A were given hesperidin (vitamin P), 100 mg. tablets, twice daily. Those in group B received Ascorbic Acid (vitamin C), 100 mg. tablets twice daily. Patients in group C were given tablets of Hesperidin-C, a combination of 50 mg. hesperidin and 50 mg. ascorbic acid in each tablet, twice daily. Blood plasma vitamin C determinations and capillary fragility tests were performed both before the study and during the period when the patients were taking the tablets.

1. We confirmed previously reported findings that a positive reaction to a capillary resistance test, such as the cuff pressure test, does not necessarily indicate a vitamin C deficiency.

2. Hesperidin (vitamin P) was found to have a beneficial effect in abnormally fragile capillaries.

3. Ascorbic acid (vitamin C) apparently did not have a beneficial effect in abnormal capillary fragility in our small series of cases.

4. Hesperidin-C, a combination of hesperidin (vitamin P) and ascorbic acid (vitamin C) was found to be effective in abnormal capillary fragility in patients with rheumatoid arthritis. These two vitamins occur together in nature and it is probable that they act synergistically; this supplementary action resulting in a much greater beneficial effect in abnormal fragile capillaries than is evidenced when either hesperidin (vitamin P) or ascorbic acid (vitamin C) is used alone.

11. Wright, I., and Lilienfeld, A.: Pharmacologic and Therapeutic Properties of Vitamin C. Arch. Int. Med. 57: 241 (Feb.) 1936.

717 W. State Street
507 S. Warren Street

STATE ACTIVITIES

CONVENTION KALEIDOSCOPE

While the Atlantic County Medical Society failed to come through with four full days of May sunshine, the 180th Annual Meeting of The Medical Society of New Jersey was a clear professional and social success. For the benefit of those unfortunates who had to spend that period in office or clinic, here are the high-spots:

MONDAY

The Finance and Budget Committee assembled to make a few last-minute adjustments in the budget. The ex-presidents of The Society entertained each other at Fellows' Dinner in one room while the Judicial Councilors had their dinner in another. At 8:00 p. m. the Board of Trustees met in the usual smoke-filled room and discussed the changes in the budget proposed that afternoon by the Finance Committee. At that meeting, Dr. Dilger's name was sent to the Crippled Children's Commission as our candidate to succeed himself on that commission, and money was appropriated to assist the work of the N. J. Formulary Research Foundation, the State Health Congress and the N. J. Health and Sanitary Association. Most of the time was devoted to formulating plans for stream-lining the veterans' care program; a recommendation was adopted proposing that most of the clerical work incident to the program be transferred to the Veterans Administration with the provision that one or more coördinators, selected from among the membership of The Medical Society be assigned to work in the V. A. Regional Office as liaison between the Veterans Administration and The Medical Society. The Trustees recommended that a special assessment of fifteen dollars per member be levied to defray the costs of this part of the project.

TUESDAY

President Alexander's gavel called to order the 180th Annual Meeting as the convention went into high gear Tuesday morning with the assembling of the House of Delegates. Minutes of the 1944 meeting of the House were approved and supplemental reports filed by various committee chairmen were read. The Treasurer's report (abstracted in *The Transactions*) was adopted. Several resolutions were introduced and referred for recommendation to the appropriate reference committees.

The General Session opened in the afternoon. First speaker was *Edward F. Stegen, Ph.D.,* Associate Administrator of the National Physicians Committee for the Extension of Medical Service. Dr. Stegen characterized the Committee as a hard-hitting, fast-moving agency for the education of the public in matters of medical economics and branded the Wagner-Murray-Dingell Bill as "the most sweeping and revolutionary measure ever introduced in our Congress". He explained that support for the committee came from individual physicians (more than 27,000 of them), from medical organizations and from "allied health industries". Dr. Stegen called on the public "to rise in holy wrath against anti-democratic ideologies". He explained that his Committee functioned outside the framework of the A. M. A. to avoid any objection to political or legislative activities by a scientific and educational organization.

Next speaker, *Dr. Perrin H. Long,* Professor of Preventive Medicine, Johns Hopkins University, and Colonel, A. U. S., reviewed medical progress and medical education during the recent war. Dr. Long criticized the withholding from responsible civilian agencies of valuable research data because of the military classification of such data as "confidential". He warned against the loose branding and assaying of penicillin, asserting that present procedures "place a premium on quantity with no reference to the qualitative character of the product". He lauded the success of American medical officers in reducing battle-wound mortality to 4 per cent (from 8 per cent in World War I) and disease mortality to one per thousand compared with seventeen per thousand in the first World War. He pointed out that the tetanus immunization program was so successful that there were only three cases of tetanus among seven million immunized personnel. On the other hand, Dr. Long deplored the inadequate opportunities for medical contacts and professional progress afforded to most medical officers, the control of medical officers by administrative officials, and the poor system for classifying medical personnel during most of the war period. "As far as continuing professional education of the medical officer was concerned, the general effect of the war was unfavorable, and the medical student's total education has been definitely deficient since 1943". Dr. Long concluded with a tribute to the combat medical officer. "Their intellectual flexibil-

ity, their ingenuity at improvisation, their constant attention to detail proved a great tribute to the system of medical education which developed these surgeons. Their record was not equalled by any other nation."

The afternoon was concluded with a talk by *Dr. Howard A. Rusk,* Rehabilitation Consultant to the Baruch Committee on Physical Medicine. Dr. Rusk reminded the audience that for every disabled soldier there are twenty severely handicapped civilians, and asserted that among these handicapped, labor turnover is smaller, absenteeism less and accidents fewer than among the physically normal. Total medical care, he pointed out, is a three phase program: prevention, cure and rehabilitation. While acknowledging the magnificent strides made in the first two phases, he called for more funds, facilities, training and personnel to bridge the gap now existing between the sick bed and the work bench.

WEDNESDAY

The scientific program opened on Wednesday. In the Section on Medicine, *Dr. Joseph C. Yaskin,* Professor of Neurology at the Graduate School of the University of Pennsylvania, spoke on the psychologic problems of the veteran and his family, hailing psychiatry as the key to the perplexing problems of readjustment. He called for educational efforts directed at both the public and the veterans, for improved interpersonal relationships and for intensive and individual guidance. He was followed by *Dr. Edgar A. Lawrence,* of the Cornell Medical College faculty, who reviewed in detail the technics of diagnosis and treatment of tropical diseases, particularly of the relapsing forms. The meeting concluded with a talk by *Dr. William D. Stroud,* Professor of Cardiology at the University of Pennsylvania, who advanced a multiphase program for the reduction of the high incidence and high mortality of heart disease.

In the Obstetrics and Gynecology Section, the management of premature labor was the opening topic. *Dr. Robert A. MacKenzie* proposed a four-point program: (a) Special attention to overweight mothers; (b) meticulously careful handling of premature babies; (c) wider use of anesthesia during childbirth, and (d) administration of vitamin K to reduce bleeding in both mother and baby. *Dr. John C. Hirst,* Associate Professor of Obstetrics, Graduate School of the University of Pennsylvania, reviewed experiences with caudal anesthesia and advocated this as a method of reducing pain, blood loss, chance of heart strain, and the duration of labor. The changes in procedure and equipment required for better protection of newborns were reported by *Dr. Charles Weymuller,* Professor of Pediatrics, Long Island College of Medicine.

The Radiology Section devoted its meeting to a symposium on congenital obstruction in the alimentary tract of the newborn. *Dr. John P. Caffey,* Associate Professor of Pediatrics, College of Physicians and Surgeons (Columbia University), reviewed the diagnosis and treatment of these obstructions in a compact monograph on the subject which was the springboard for much discussion.

First speaker in the Section on Eye, Ear, Nose and Throat was *Dr. Irving Leopold* of the Ophthalmologic Department of the University of Pennsylvania, who talked on penicillin in ocular diseases. Dr. Leopold urged the local administration of the drug, which he found especially valuable in infections of the eyelids and lacrimal ducts and in certain forms of corneal ulcer. In appraising any proposed ocular drug, the speaker laid down two prime desiderata: (1) That the medication actually reach the ocular fluids in potent concentration, and (2) that it exercise no deleterious effect on the sensitive eye tissues. This was followed by a symposium on eye and ear casualties in the Army and Navy, with a panel of five medical officers: *Lt. Colonel Randolph* of the Army, and *Captain Fred Harbert* and *Lieutenants Eva Thompson, Margaret Paul* and *W. G. Hardy* of the Navy.

In the afternoon, *Dr. Damon B. Pfeiffer,* Director of the Surgical Clinic of the Abington Memorial Hospital, opened the Surgical Section with a talk on carcinoma of the rectum. He reported disappointing experiences with radiation but cited a salvage rate in excess of 50 per cent with surgery. The surgical approach, Dr. Pfeiffer pointed out, should remove the lesion and remove "a generous portion of normal tissue on all sides of the growth" as well as the areas of lymphatic spread. The speaker closed with a plea for better understanding of colostomy, pointing out that if the cancer is successfully removed, "patients will live normal lives even with an artificial stoma". The Surgical Section continued with a talk on venous thrombosis by *Dr. Robert Linton,* Chief of the Vascular Clinic at Massachusetts General Hospital. Dr. Linton recommended use of the new anti-clotting drugs like dicumarol and heparin, though warned that these medications should be used only under strict control since in overdose there was always danger of hemorrhage. The speaker described operative procedures on the leg veins to removed sources of pulmonary thrombi and urged that wherever possible, patients be encouraged to get out of bed and walk on the second day after an opera-

tion. Final speaker was *Dr. Reginald Smithwick,* who discussed the operation which bears his name and reviewed the indications, contraindications and technical procedure.

The Section on Pediatrics devoted its time to a seminar on rheumatic fever. The clinical discussion was opened by *Dr. William D. Stroud,* Professor of Cardiology at the University of Pennsylvania, who was followed by *Dr. George M. Wheatley,* Assistant Medical Director of the Metropolitan Life Insurance Company. Dr. Wheatley urged that teachers be alerted to the early recognition of rheumatic fever symptoms in school children and asked that schools establish a special service by which all necessary diagnostic facilities would be made available to physicians. Better and more thorough physical examinations of school children were called for. Rheumatic fever, in the opinion of *Dr. J. F. Hiss,* Professor of Medicine, University of Syracuse, is a community problem. It costs communities more to take care of cardiac victims and their dependents than it would to set up a preventive program. Such a program should embrace six features: (1) An educational campaign, (2) case finding technics, (3) diagnostic aids, (4) a special hospital, (5) follow-up clinics and (6) vocational guidance. Experiences with state programs for the control of rheumatic fever were presented by *Dr. Arthur J. Lesser,* Regional Medical Consultant in the Children's Bureau. Dr. Lesser deplored the fact that only twenty states have taken advantage of the federal funds made available to assist state health departments in developing services for cardiac children.

First speaker in the Section of Gastro-Enterology and Proctology was *Dr. Manfred Kraemer* of Newark, who reported on the technic for adequate stool study worked out in an Army hospital in England. Essential features of the program were: (1) At least three specimens per patient, (2) collection of specimens directly in the laboratory rather than their transportation from the ward to the laboratory, (3) use of warm-stage microscope for examining specimens and (4) specialized training for laboratory technicians. *Dr. Frank W. Co Tui,* Associate Professor of Experimental Surgery at New York University, next reviewed the status of amino acids in the treatment of peptic ulcer; and the management of the commoner disorders of the anus and rectum was discussed by *Dr. Julius Gerendasy* of Elizabeth. A monographic study of esophageal hiatus hernia was presented by *Dr. Louis L. Perkel* of Jersey City, who reported on a series of 51 such cases. The characteristics of the roentgenogram in esophageal hernia were pointed out in a series of slides and films and the relative value of the several treatment procedures (diets, surgery and antispasmodics) was assayed.

The House of Delegates held its second session at noon and unanimously elected the following officers for 1946-47:

President—Frank G. Scammell, Trenton
President-Elect—Royal A. Schaaf, Newark
First Vice-President—J. Howard Hornberger, Roebling
Second Vice-President—James F. Norton, Jersey City
Secretary—Alfred Stahl, Newark
Treasurer—George J. Young, Morristown
Trustees—First District (3 years)—E. Zeh Hawkes, Newark
Fourth District (3 years): William E. Dodd, Beach Haven
At Large (3 years)—Elton W. Lance, Rahway
Councilors—Third District (3 years)—Barclay S. Fuhrmann, Flemington
Delegates and Alternates to the A.M.A. (1947 and 1948 meetings)
Delegate (2 years)—Wells P. Eagleton, Newark
Alternate (2 years)—Elmer P. Weigel, Plainfield
Delegate (2 years)—Hilton S. Read, Ventnor
Alternate (2 years)—Lancelot Ely, Somerville
Delegate (2 years)—Thomas K. Lewis, Camden
Alternate (2 years)—Clarence W. Way, Sea Isle City
Delegate (1 year)—William F. Costello, Dover
Delegates and Alternates to Other States (1947 meeting)
New York—Delegate (1 year)—James F. Norton, Jersey City
Alternate (1 year)—D. Ward Scanlan, Atlantic City
Connecticut—Delegate (1 year)—Alfred Stahl, Newark
Alternate (1 year)—C. Byron Blaisdell, Long Branch
Standing Committees
Publication (3 years)—Lewis W. Brown, Newark
Scientific Work—Third District (5 years)—Patrick H. Corrigan, Trenton
Finance and Budget (6 years)—L. Samuel Sica, Trenton

After six scientific sections, an election, and a cocktail party, the Annual Meeting settled down to the social highspot of the week, the banquet.

Dr. Hilton S. Read, the toastmaster, kept the capacity audience amused with witty comment. *Dr. Londrigan* presented the Fellow's Key to the retiring President, *Dr. Alexander,* who responded with brief remarks, paying tribute to the work of the Woman's Auxiliary and to the war record made by the 1500 members of The Medical Society of New Jersey who served in the Army and Navy. Dr. Alex-

ander called on the doctors to meet the challenge of fashioning a way of distributing medical care to all the public at a price they can afford to pay. He announced the establishment of our State Health Congress, hailing it as a new venture, long overdue and as a unique plan for affording a voice to the consumers of medical care as well as the renderers of such care. He closed with a plea for doctors to assume more active rôles in civic and communal affairs.

Major General Paul R. Hawley, Chief Medical Director, Department of Medicine and Surgery, Veterans Administration, was the essayist of the evening, and after a story about a talking cow, stated his position as one of threefold responsibility to the Administration, to the veterans and to the medical profession. He admitted that many of the complaints made against the Veterans Administration last year were true but added that many of the much publicized grievances were exaggerated. He characterized the Veterans Administration, at the time General Bradley inherited it, as "riddled with dry rot" and ascribed this to several factors, including poor pay to doctors, the strangulation of professional service by Civil Service, poor classification of medical personnel, the influence of pressure groups and the tortuous channel between medical personnel and the top administration of the Veterans Administration.

The General asserted that the majority of the men in the Veterans Administration are suspicious of the changes now being made. In January the Veterans Administration needed 3600 full-time physicians and had only 1200 permanent medical personnel. At present, the Veterans Administration offers more to M.D.'s than any other Federal Service and by the end of May, the Veterans Administration had 3200 full-time doctors.

On the often criticized policy of limiting top-ranking positions to Board Diplomates, General Hawley explained that rigid standards were a practical necessity, although he recognized that a Board Diploma was a mechanical, not necessarily accurate, test of skills. With reference to the out-of-way location of some of the veterans' hospitals, the General said: "Our elected representatives confused our hospitals with post offices."

He reported that until recently, the Veterans Administration had contracts with ten states for provision of out-patient care for veterans by their own doctors, and that since New Jersey had cancelled its contract—which he deplored—the number was only nine.

He credited Monmouth County with the origin of the present plan for out-patient care and stated that every plan in the country was an outgrowth of the Monmouth County idea.

THURSDAY

The final day of the Annual Meeting was opened with a talk by *Dr. William B. Rawls,* Chairman of the Coördinating Council of the Medical Societies of New York. Dr. Rawls pointed out that disease bore a definite relationship to poor housing, inadequate rest and unbalanced diets and suggested that the reformers aim their ammunition at those problems. He praised the individualized system of medical care as one which has given this country the best health record of any nation on earth.

Slow but hopeful progress has marked the advance of cancer research during the last five years, said *Dr. Cornelius P. Rhoads,* Director of the Memorial Hospital in New York City. Dr. Rhoads listed four channels of advance. One was the control of certain forms of genital cancer by administration of the antagonistic hormones; another was the observation that many patients with gastric carcinoma showed striking metabolic disorders; third, the discovery that one of the toxic military gases could control some forms of lymphoid cancer; and fourth, the finding of abnormal hormones in the excretions of some patients with carcinoma.

The House of Delegates assembled for its final business session with a review of the reports of the Reference Committees. The House voted to increase the dues to $25.00 a year and to adopt the plan of installing medical coördinators in the Regional Offices of the Veterans Administration. Dr. Scammell was inaugurated as President of the Society and devoted his talk to reminiscences of medical practice in New Jersey at the turn of the century.

Full accounts of the proceedings of the Annual Meeting will be published in the *Transactions,* which will be released as a supplement to the August issue of this *Journal.*

The attendance figures at the Annual Meeting follow:

Members of The Medical Society of New Jersey	758	
Visiting Physicians	55	
Total Physicians		813
Woman's Auxiliary Members		196
Visitors		274
Exhibitors		100
Total Registration		1,383

ATTENDANCE

County	Delegates	Members	County Registration	Woman's Auxiliary
Atlantic	8	69	77	27
Bergen	12	18	30	6
Burlington	7	8	15	11
Camden	11	49	60	18
Cape May	4	6	10	
Cumberland	4	8	12	
Essex	48	115	163	38
Gloucester	5	5	10	11
Hudson	29	33	62	11
Hunterdon	1	3	4	
Mercer	15	54	69	25
Middlesex	9	28	37	8
Monmouth	4	30	34	5
Morris	9	12	21	
Ocean	1	4	5	6
Passaic	15	29	44	18
Salem	4	1	5	
Somerset	2	9	11	1
Sussex	1	1	2	
Union	23	57	80	7
Warren	3	4	7	4
Totals	215	543	758	196

TUMOR SYMPOSIUM IN NEW YORK

Tumors will be the theme of this year's Graduate Fortnight of the New York Academy of Medicine. The Annual Fortnight will be held between October 7 and October 18. Panel discussions are held in the morning, hospital clinics in the afternoon and lectures in the evening. For detailed program write to: Graduate Fortnight Committee, Academy of Medicine, 2 East 103rd Street, New York 29, N. Y.

ILL AWARD TO DR. SCHLICHTER

The Academy of Medicine of Northern New Jersey was the scene on May 16, 1946, of the conferring of the Edward J. Ill Award on Dr. Charles H. Schlichter of Elizabeth, N. J. Ceremonies opened with an introductory talk by the president of the Academy, Dr. Lee W. Hughes.

ADDRESS BY DR. HUGHES

"Tonight will be the last time that I will have the privilege of addressing you as your president. Therefore, it is only proper that I express to you my thanks for the loyalty and coöperation you have given me through my term of office, and my wish that you will lend the same spirit of helpfulness to my most worthy successor, Dr. Joseph I. Echikson.

"The Academy of Medicine of Northern New Jersey recently celebrated its thirty-fifth birthday. During its existence it has served a useful purpose to the medical and dental professions, and to the community at large. The prime purpose of the Academy was to furnish a place where medical men might meet to discuss subjects pertaining to medicine, and to increase their knowledge in various phases of their chosen field. To this end, sections were formed to deal with special subjects—ophthalmology, otology, medicine, surgery, obstetrics, etc. To each of these sections during their monthly meetings have come many men of national and international reputation, to address them in some special field of medicine and surgery. They have made these meetings truly inspiring to the medical men of Northern New Jersey.

"One thought prominent in the minds of the founders of the Academy was to have a place where medical books and journals might be housed that all professional men, members and nonmembers, might have free access to them. Through the years, thousands of periodicals, medical journals, even entire medical libraries have been donated to the Academy; and many medical journals and books have been purchased by the Academy itself, until today we have a medical library housed in this building that is second to none. Our affiliations with other medical libraries throughout the country make it possible for any physician to have free access to all printed medical knowledge.

"The growth of the Academy has been steady throughout the years, though there have been times when the going has been rather difficult, especially during the depression and war years. With the return of all of our members from the armed forces, together with the recent graduates, along with many others who will be seeking admission to the Academy, we can look forward to a happy and prosperous future.

"During the presidency of Dr. Henry C. Barkhorn, the Academy of Medicine of Northern New Jersey established the Edward J. Ill Award in recognition of the outstanding professional attainments of the man for whom it was named. The original description of the Award is as follows: *'This Award shall be given at such times as the Council deems wise to that doctor of Northern New Jersey who merits it for his extraordinary services as a physician and as a citizen.'* This Award has been given on seven previous occasions. Six recipients of this Award are still living; several of them are here tonight. The Award need not necessarily be given each year. Indeed, it is reasonable to assume that as time goes on there will be fewer candidates able to meet the requirements of the original provisions.

"The candidate chosen by the Council to receive the Award tonight is Dr. Charles H. Schlichter of Elizabeth, New Jersey, who by his professional attainments and by his services to the commonwealth of New Jersey, richly deserves the honor we wish to bestow upon him.

"The citation and presentation of this Award will be made by one of the outstanding physicians of our community, one who served his country with distinction in World War I and World War II. I now have the pleasure to present Dr. Earl LeRoy Wood."

CITATION BY DR. WOOD

Before presenting the award, Dr. Earl LeRoy Wood addressed the meeting as follows:

"When this Academy of Medicine decided to confer upon you the Edward J. Ill Award it did not realize that you were completing your first fifty years as a Doctor of Medicine. However, the coincidence is fortunate because a golden wedding is always an occasion of distinction. When it marks fifty years of union between character and personality with the healing profession, it is an event calculated to stir the emotions and to stimulate others to emulation. In your fiftieth anniversary in the practice of medicine, we have more than the commemoration of half a century of service to the ills of the body. It also celebrates years of activity on behalf of many good causes—civic, military and benevolent— and the Edward J. Ill Award is made, because you have distinguished yourself both as a physician and as a citizen.



Dr. Wood presenting the Edward J. Ill Award to Dr. Schlichter



The Edward J. Ill Award, 1946

"You are, first of all, an able, wise and progressive physician, beloved of your patients and respected for character and professional abilities. What you have done for the relief of human suffering is written large in many a life in the community.

"After first graduating in pharmacy you received your medical degree from the College of Physicians and Surgeons in New York in 1896, then spent a year under Dr. Ill (for whom this award is named) as intern at the German Hospital in Newark. Upon returning to your birthplace, there began your long association with the Elizabeth General Hospital which you served in all capacities, from dispensary physician to chief of staff. At the same time you made your abilities as an eminent ophthalmologist available to hospitals in Newark and Rahway and served as a State Commissioner for the Blind.

"With prophetic insight and wisdom several years ago you envisaged the need of a tumor clinic and with persistent, productive and inspirational leadership developed that essential organization. In you, the city of Elizabeth has indeed a true devoted son. You served as a Trustee of its Free Public Library for almost forty years, several of these as its president. For a busy physician to strengthen and guide this institution so important to our democracy again reveals the large conception of your obligation to your fellowman.

"Early in your career came the Spanish-American War. Instantly you gave your services to your country, serving as First Lieutenant and Battalion Surgeon to the old Third New Jersey Volunteer Infantry. In 1917 you left a busy practice again to answer your country's call. After commanding a base hospital, you retired with the rank of colonel.

"In the recent war, the third to claim your abilities, you became the top-ranking representative of the civilian doctors in New Jersey in their coöperation with the military effort, serving as chief of the Emergency Medical Service, Senior Consultant for the United States Public Health Service and Chairman of the Procurement and Assignment Committee. No civilian medical job was more difficult, more important or provoked more headaches than that of administering Procurement and Assignment work. You, however, carried through the program with efficiency, impartiality and distinction.

"On this occasion when your character is being scrutinized and openly appraised, two of your many worthy qualities provoke our frank admiration, your self sacrifice and your courage. When the cause was worthy and just your energies were enlisted without first appraising the effort in personal terms. On many occasions public duty demanded so much that your personal interests, private practice and individual convenience were sacrificed.

This you bore without complaint. Courageously you have often championed policies when convinced of their moral justice or patriotic necessity, undeterred by the prospect of disapproval and the certainty of opposition. Courageous, unselfish service has been conspicuous throughout your life and truly service is the measure of greatness.

"This citation and public expression of admiration is an addition to many you have justly received. Army Surgeons General Ireland of World War I and Kirk of World War II, Navy Surgeon General McIntire, as well as senior officers of our state, have all expressed their admiration and appreciation of your work on previous occasions. Let it be said, however, that this award has an added distinction: it includes the personal affection and admiration of your neighbors—those who see you daily and love you well.

"The presentation of this bronze plaque, the Edward J. Ill Award, is the outward and visible sign of the inward homage of our hearts and minds. In honoring you, Dr. Schlichter, we are honoring ourselves, for in you are embodied the incorruptible integrity, the professional distinction, the rich conception of public service and the human friendliness that together give eminence to a doctor of medicine. We would say of you as was said of another in days past: 'And thus he bore without abuse, the grand old name of gentleman.'

"To this we would add three other titles: *Noted Physician, Zealous Executive, Esteemed Citizen.*"

The Award was then presented and Dr. Schlichter responded as follows:

DR. SCHLICHTER'S RESPONSE

"While listening to Dr. Hughes and Colonel Wood it seemed as if I were here as a spectator, come to help honor someone else. Surely their laudatory remarks could never refer to me and the work in which I have been engaged for many years. I knew I had been present and worked on the several projects that have been mentioned, but each was just a job in the day's routine for me. The big work of so many of my colleagues served as an inspiration to do my own best. In the days that have passed, my sole ambition was to carry out for my fellowman the mission embodied in the oath of our profession. Honors for this work were the last in my thoughts. To have my name added to the list of distinguished doctors to whom you have given this award—Dr. Eagleton, Dr. Danzis, Dr. Hawkes, Dr. Bingham, Dr. Martland, Dr. Barkhorn and Dr. Sprague—is, in itself, a great honor indeed. The Edward J. Ill award is one of the outstanding, if not the outstanding honor, that can come to a New Jersey doctor. College and university degrees are achieved in many ways but this award comes from those with whom the recipient has lived and worked in his civic and professional life and therefore merits a high place.

"This Award exemplifies the life of Dr. Edward J. Ill as a Doctor of Medicine and a public-spirited citizen. As a Doctor of Medicine, besides his high technical and scientific endowments, he was ever mindful of the welfare of his colleague, as is so markedly shown (to cite but one example) by his devotion to and his work for the Society of Widows and Orphans of Medical Men of New Jersey. As a citizen, his leadership in the development of hospital facilities in Newark, the state, and in the many other ways in which he furthered the welfare of the citizens of New Jersey shows the high civic duty he placed upon himself.

"It was my good fortune to have begun my medical career as one of the interns of the then German Hospital here in Newark, and to serve under Dr. Ill, Dr. Dieffenbach, Dr. Lehlbach, Dr. Seidman, Dr. Seidler and the others of that staff. These men with Dr. Eagleton, Dr. T. Y. Sutphen and Dr. Charles Kipp were the leaders of medicine whom I met when I came to Newark.

"In my native city of Elizabeth and county of Union such men as Dr. James S. Green, Sr., Dr. Alonzo Pettit, Dr. Victor Mravlag (my preceptor in medicine), Dr. Norton L. Wilson, Dr. William A. M. Mack, Dr. Thomas McLean, Dr. Job Crane, Dr. James S. Green, Jr., Dr. E. B. Grier and many others were living examples of the type of men who composed the medical profession of that day.

"It was a great period for a young medical man. He drew inspiration and ideals of ethical conduct from these giants of their time. They were true disciples of Aesculapius, and the Hippocratic Oath was a real guide to their professional and personal conduct of living. They were among the many who pioneered in those early days of the progress of medicine. They had caught the spirit of Semmelweiss, Pasteur, Lister, Skoda and Koch, Oliver Wendell Holmes and Virchow, Walter Reid and Gorgas, Deaver, Halstead and Kelly, DaCosta, Ewing and McBurney and were making every effort to spread the truths that were unfolding so rapidly. Such men as these were the leaders in founding the many medical and clinical societies of our country.

"In these societies, particularly the small ones, the great discoveries and new methods were hailed with enthusiasm and discussed at great length. It was considered a privilege to attend these meetings and when one was detained by an obstetrical case or other emergency one felt the loss of such a meeting keenly. No social engagement, theatre or an evening of whist was ever allowed to interfere with attendance at these meetings. I speak of this to show how the imagination and desire for study was stimulated in the young medical men of my youth. To a great extent this is true today, but I often wonder at the really small attendance in proportion to the membership of such societies today.

"It was the spirit of the early men of medicine who were ready to throw off the belief of yesterday and accept the teaching of today that has given us the marvelous record of the progress and scientific achievement of the past fifty years; diphtheria, scarlet fever, gastro-enteritis in infants (the so-called summer complaint so ably conquered by the late Dr. Coit in his great crusade for clean milk), trachoma, typhoid fever, yellow fever, tuberculosis, syphilis and many others such as malaria and appendicitis are no longer scourges on our people. We may all take a pardonable pride in the work of our profession to benefit mankind. We live longer and under better conditions than did our parents and grandparents, all due to the unselfish, altruistic spirit which has motivated our profession and made it the respected one it is.

"There is, however, a thing that has disturbed me for some time. That is, the growing importance that is placed on the economic side of medicine. Of course, the laborer is worthy of his hire. The doctor and his family must live and live decently and if wise, look to a suffilent income for his older years. However, in the past few years, it has seemed to me that just a little too much emphasis has been given this question. May I make a plea that this spirit shall not go too far? Some will

enter the practice of medicine to make money rather than to serve their fellowmen should this spirit grow; then we must expect to have our grand old profession with its glorious past history go down to a mere commerical pursuit and thus lose the prestige and honor which is even now beginning to wane. God grant that this may never occur. We must be watchful and by our conduct and performance always be an example of the true physician. At the risk of being accused of preaching, may I say to our young men and women of medicine: Be guided by the spirit of such men as I met when I entered medicine; hew to the line of the great principles of the fathers of medicine; do not listen to false prophets; keep away from the temptation to get all the traffic will bear; always put your patient first; if you do this, you will, as you look back on your life, have the greatest reward in the satisfaction of having lived a good, useful, serviceable life and you will have the feeling that you leave the world a little better off than when you entered it. No amount of material or financial success can equal this. Doctors should take an interest in their community, state and nation. Get close to the people. Join some civic group or service club. Get out of the rut of a too closely pursued medical life. See to it that the doctor's point of view gets before the people. If that is done, we will not be troubled long by the cults and 'isms' now so vociferous. See to it, also, that people understand medical care, and above all be sympathetic to its greater distribution by strongly supporting what your State Society is trying to do with this problem. Let me quote from Emerson a fine piece of advice which may apply to many of us:

"'Finish each day and be done with it. You have done what you could. Some blunders and absurdities, no doubt, crept in. Forget them as soon as you can. Tomorrow is a new day. Begin it serenely, and with too high a spirit to be encumbered with your old nonsense.'

"As to my humble self. It never occurred to me that such an honor as the Edward J. Ill Award could ever come to me. I accept it with deep gratitude to my colleagues without whose help I could have accomplished nothing. And here I wish to pay tribute and give thanks to Dr. Norman M. Scott who has been a friend, a tower of strength and a fount of knowledge and wisdom in our Procurement and Assignment work. He gave much of himself to this task. More than will ever be known except to those of us who worked closely with him.

"To the New Jersey Advisory Committee of Procurement and Assignment I also owe much. Their sympathetic backing, often pointing out the way of greater service, was a great help and made the work easier. To all of these medical men who helped so generously to organize and put into practical shape for instant use, the emergency medical service of Civilian Defense—these men and women, the doctors and nurses, did a stupendous job which the citizens of New Jersey will never fully realize or appreciate. It gives me a great personal satisfaction publicly to express my thanks and my appreciation to them.

"This distinction which you have so graciously conferred upon me this evening is the crowning honor of my life. This Award will be the greatest heritage I can leave to my children and grandchildren. I take it with deep humility, yet with a proud spirit since it comes from those who, outside my wife and family, are nearest and dearest to me, my colleagues—the Doctors of Medicine of New Jersey."

TRUSTEES' MEETINGS

Regular meeting of the Board of Trustees was held at 2 p. m., Sunday, April 7, 1946, at the State Society Headquarters, Trenton.

Present were: Dr. James F. Norton, Chairman, who presided; Dr. E. Zeh Hawkes, Dr. Royal A. Schaaf, Dr. William E. Dodd, Dr. George J. Young, Dr. Thomas B. Lee, Dr. Samuel Alexander, Dr. Alfred Stahl, Dr. Frank G. Scammell, Dr. William F. Costello, Dr. George W. Fithian, Dr. Joseph F. Londrigan and Dr. Aldrich C. Crowe. Also present upon invitation were Dr. Henry C. Barkhorn and Dr. Norman M. Scott.

Minutes of the January 27th meeting of the Board of Trustees were approved.

REPORT OF THE PRESIDENT

President Alexander reported that since the last meeting of the Board of Trustees he had attended the following meetings:

January 31—Regional Conference of the A. M. A. in Philadelphia
January 31—Essex County Medical Society Conference with Legislators
February 8—Regional Meeting of the American Legion in Atlantic City
March 22—Addressed the Annual Meeting of the New Jersey Health and Sanitary Association in New Brunswick
March 24—Inaugural meeting of the New Jersey Health Congress. Present were representatives of those rendering service and the consumer.

President Alexander stated that the hearings on the Wagner-Murray Bill had started on April 2. Organized Medicine will present its point of view on April 18. The A. M. A. will be permitted two hours for its presentation. State Medical Societies will have opportunity to present a written brief for the record but will not be given time for verbal presentation before the Committee.

President Alexander gave a brief report on the speakers and their topics for the banquet and general sessions at the 1946 Annual Meeting.

REPORT OF FINANCE AND BUDGET COMMITTEE

Dr. Costello, reporting for Dr. North, Chairman of the Finance and Budget Committee,

presented the following recommendations from the Committee:

1. That Dr. Quigley's salary, as Executive Secretary to the Legislative Committee, be increased to $5,000 and that bonus be eliminated, effective June 1, 1946.
2. That the Society give the Auxiliary $600 to help defray traveling expenses of their six delegates to the A. M. A. in San Francisco.
3. That office salaries be made all inclusive of bonus and overtime now paid, beginning June 1, 1946.
4. That the salaries of the Executive Office Secretary, Miss D'Arcy, and the Editorial Secretary, Mrs. Armstrong, be increased to a maximum for their positions of $3,000 per year, beginning June 1, 1946.
5. That the Accident Insurance carried on physician employees be discontinued.
6. That the Board of Trustees adopt the policy that remuneration paid to employees injured while working in their capacity as an employee of the State Society be limited to the benefits provided under the Workmen's Compensation Act.
7. That the salary of Dr. Scott (additional salary payable through Medical Service Administration) be increased to $3,500, effective June 1, 1946.
8. That the Publication Committee be requested to submit the details of its contract with Mr. Knoepfel, advertising agent, for review.

Dr. Costello stated that provision had been made in the tentative budget for $10,000 salary for an Executive Officer.

Chairman Norton urged that the Board of Trustees set up a policy of the Society defining the functions of an Executive Officer, a Public Relations Officer, a Public Relations Secretary and a Legislative Secretary.

The final motion which was unanimously passed was as follows: That the Board of Trustees approve the recommendations and request of the Finance and Budget Committee with the exception of No. 5 and No. 6.

CONFERENCE OF STATE PRESIDENTS

Dr. Stahl presented a communication from the Secretary of the Conference of State Presidents of Medical Associations requesting a contribution of $50 from The Medical Society of New Jersey toward the budget of the organization for the current year.

Dr. Lee moved that the requested $50 contribution be forwarded to the Conference of State Presidents, to be charged to the account known as Conference Dues. Unanimously carried.

VETERANS CARE PROGRAM

Dr. Scott read a detailed report of the activities in connection with the Veterans Medical Care Plan, a copy of which is on file in the Executive Offices.

Dr. Scott stated that the $5000 loan to Medical Service Administration from the Medical Society for organization expenses in connection with the Veterans Care Plan, had not been accepted, on advice of counsel, as this would have made Medical Service Administration insolvent.

Dr. Alexander moved that the Board of Turstees rescind its action of January 27, 1946, granting a loan of $5000 to Medical Service Administration for Veterans Medical Care Plan. Unanimously carried.

Dr. Alexander moved that the Board of Trustees make a grant of $5000 to Medical Service Administration for use in connection with the Veterans Medical Care Plan, the sum to be charged to the account of Medical Service Administration. Unanimously carried.

REPORT OF WELFARE COMMITTEE

Secretary Crowe read the following report of the Welfare Committee:

The Welfare Committee met in Trenton on Sunday, March 31st. The following actions were taken:

a. That the Advisory Committee on Private Practice be discontinued as its functions overlap those of other advisory committees.

b. That the Advisory Committee on Auxiliary Medical Services be discontinued and its specialties be set up in the following three new advisory committees:

Physiotherapy
Radiology
Anesthesiology

The reports of the other three Sub-Committees noting the activities and progress in their programs were approved as presented by the various Chairmen.

Dr. Alexander moved that the recommendations contained in the report of the Welfare Committee be adopted. Unanimously carried.

RESOLUTIONS ON DEATH OF DR. McBRIDE

President Alexander, reporting for the Committee appointed to draw up resolutions on the death of Dr. Andrew F. McBride, read the following resolutions:

ANDREW FRANCIS McBRIDE, M.D.,
F.A.C.S., K.S.G.
1869 - 1946

The death of Andrew F. McBride marks the passing away of one of the real links between the old and the new in the membership of The Medical Society of New Jersey. We loved and revered Dr. McBride during his life as we honor and reverence his memory now that he has passed to his reward. He was an upright, public-spirited, humble and charitable doctor and citizen.

As President, and for many years as a Trustee of The Medical Society of New Jersey, he brought to our councils a rich fund of good sense and sound judgment and his kindly face lit up our most serious discussions.

There is little need to record his many activities in his city and county, in his state and in the medi-

cal councils of the nation and for his church. They have all appeared in the press and in the *Journal* of the Society.

To commemorate the high regard and genuine affection we have for our departed co-laborer and friend, it is hereby

Resolved, That the foregoing memorial of the esteem in which we held him and which we will continue to foster within our hearts, be spread upon the records of this Society and be published in the *Journal,* and it is further

Resolved, That a copy thereof be sent to his beloved family.

Dr. Alexander moved that the resolutions be approved by the Trustees. Unanimously carried.

REPRESENTATIVE OF HOSPITAL PLAN BOARD

President Alexander announced that he had recommended the reappointment of Dr. Joseph F. Londrigan, for one year, as a member of the New Jersey Hospital Service Plan Board.

Upon motion, seconded and unanimously carried the Board concurred in President Alexander's action.

McBRIDE MEMORIAL COMMITTEE

President Alexander reported that to date, sixty-one physicians had contributed $886.00 to the McBride Memorial Fund, of which $791.00 has been sent to the headquarters in Paterson.

DR. SCOTT TO A. M. A. CONVENTION

Upon motion by Dr. Alexander, seconded by Dr. Londrigan and unanimously carried, it was directed that Dr. Norman M. Scott be sent to the American Medical Association Convention in San Francisco in July, expenses to be paid by The Medical Society of New Jersey.

COMMUNICATION FROM RADIOLOGIC SOCIETY

President Alexander read a communication from the New Jersey Radiologic Society raising objection to the second paragraph of the contract between Veterans Administration and Medical Service Administration, which reads in part:

"The Veterans Administration will authorize examination, treatments and counsel. All authorizations for such services to be rendered New Jersey veterans, except laboratory, x-ray and physical therapy services to be rendered veterans while bed patients in hospitals as a hospital service will be issued to the Medical Service Administration . . ."

President Alexander also read a letter from Dr. Scott to the Radiologic Society explaining the wording of this paragraph and the reasons for it. (Copy of letter on file in Executive Offices.)

It was pointed out that the problem of x-ray services being included as hospital services is the same as that which has been under consideration by the Inter-Professional Relationships Committee and the representatvies of the Hospital Association.

Dr. Schaaf moved that the Board of Trustees endorse and confirm the principles and ideas expressed in Dr. Scott's letter to the Radiologic Society and that the Society be informed that The Medical Society of New Jersey is giving the problem serious consideration, and that the outcome will have to await passage of pending legislation which will permit Medical Service Administration to make contracts with hospitals in connection with medical care rendered hospitalized veterans. Unanimously carried.

FORMULARY RESEARCH FOUNDATION

Secretary Crowe read a communication from the Committee on Pharmaceutical Problems stating that the Committee had approved a plan to create the New Jersey Formulary Research Foundation at Rutgers University, College of Pharmacy. Chief purpose of the plan is to develop and experiment with formulas for future issues of the New Jersey Formulary. This has been approved by the New Jersey Pharmaceutical Association which has contributed $500 toward defraying the cost of the project. The Committee on Pharmaceutical Problems urged approval of this project and financial support by the Board of Trustees.

Upon motion, unanimously carried, consideration of this matter was deferred until the next meeting of the Board.

CANCER SURVEY OFFICE

Secretary Crowe read communications from Dr. Keir, Chairman of the Cancer Control Committee, and Dr. Emil Frankel, requesting temporary office space in the Home of The Medical Society of New Jersey for purposes of conducting a survey of cancer treatment facilities in New Jersey.

Dr. Lee stated that the survey of cancer facilities, being conducted by Dr. Snegireff, is nearly completed, and since the office of the New Jersey Cancer Society is in Newark, and because of lack of available space at the State Society Headquarters, he did not feel it wise to offer space to the group in the State Society offices.

Upon motion, unanimously carried, request for office space in the State Society Headquarters for the cancer survey group was refused.

The meeting was adjourned at 4:25 p. m.

A special meeting of the Board of Trustees was held at the State Society Headquarters on May 5, 1946. The session was called to order at 2 p. m. by Chairman Norton, who advised that the Board was convened to consider certain urgent aspects of the operation of the Veterans Care Program by the Medical Service Administration.

The situation was outlined by President Alexander and Dr. Scott as follows:

On April 28, Dr. Scott had reported to the Medical Service Administration Board that the machinery for operating the Veterans Care Program was inadequate for the volume of case material being sent through it. Accordingly a conference was held on May 3 at which Drs. Alexander, Scott and Blackburne met with Messrs. Rogers and Miller and Dr. Ranone of the Veterans Administration. Mr. Rogers expressed willingness to regulate the flow of new cases for processing by Medical Service Administration, to the extent that the facilities of M. S. A. would permit. He reported that his budget called for an expenditure of $1,285,000 for the fiscal year ending June 30, 1947, for examination and treatment fees for cases to be processed through Medical Service Administration.

Dr. Scott suggested that the program was, in essence, a business venture, and that it should be headed by a business administrator rather than by a physician. He called attention to the fact that in California and in Michigan the program is directed by an administrator who receives an annual salary of $15,000. President Alexander urged that the Veterans Care Program in New Jersey be retained, since if it were abandoned, our contract with V. A. would be cancelled and the private practitioners of our state would have little or no part in the care of veterans.

On motion of Dr. Schaaf, the following resolution was adopted:

That The Medical Society of New Jersey underwrite the expenses of Medical Service Administration on the Veterans Care Program for an additional sixty days (from May 5) and that during this period, every effort be made to clear existing difficulties by making contacts with the highest officials in the Veterans Administration.

On motion of Dr. Hawkes the following resolution was adopted:

That the Medical Service Administration ask the Veterans Administration in Washington if it will take over administration of the Plan in New Jersey.

On motion of Dr. Costello, the following resolution was adopted:

That a committee consisting of Dr. Norton, Chairman of the Board; Dr. Alexander, President of the Society, and Dr. Schaaf, First Vice-President, investigate the Veterans Care Program and make a report with recommendations to the May 20 meeting of the Board of Trustees; and that the result of the deliberations of the Trustees after hearing this report, be submitted to the House of Delegates at the 1946 Annual Meeting.

Meeting was adjourned at 5:45 p. m.

TROPICAL DISEASE ITEMS

BY THE COMMITTEE ON TROPICAL DISEASE

The health problems of the South and East (tropics) will soon be our problems.

Filariasis: It is possible that returning filarial infected troops may transmit through mosquitoes their infection to other individuals in this country. This, however, is rather unlikely and, although we should be aware of the possibility and do what we can to prevent it, and it does not appear to be of any great importance. Brown, H. W., Am. J. P. H. 35: 613, June 1945.

Scrub Typhus (Tsutsugamushi Fever): The Cairo Unit of the U. S. A. Typhus Commission recommends a clinical trial of paraaminobenzoic acid in human tsutsugamushi disease (Scrub Typhus). Editorial J. A. M. A. 130:5 (Feb. 2) 1946. For a complete paper on Scrub Typhus see Scrub Typhus, Browning, J. S., et al., Am. J. Trop. Mea. 25: 48, Nov. 1945.

Leprosy: Promin has been used in leprosy of the hepromatous and mixed type with reported improvement. Pub. Health Rep. 60: 1165 (Oct. 5) 1945.

The therapeutic action of citronella oil in leprosy is reported by J. Degatte in Leprosy Review, 15: 28, Dec. 1944.

The "General Practitioner and Leprosy" is reviewed with illustrations in the Journal of the Missouri State Medical Association for April 1945. The article is by N. Tobias, M.D.

CHRISTIAN P. SEGARD, M.D., Chairman,
Tropical Disease Committee.

WELFARE COMMITTEE—MARCH 31, 1946

Present were:

SIGURD W. JOHNSEN, Chairman
HERSCHEL S. MURPHY, Vice-Chairman
SAMUEL ALEXANDER
ALFRED STAHL
D. WARD SCANLAN (Atlantic)
FLOYD E. KEIR (Bergen)
S. EMLEN STOKES (Burlington)
HENRY B. DECKER (Camden)
GEORGE F. DANDOIS (Cape May)
H. BURTON WALKER (Cumberland)
ALBERT B. KUMP
HARROLD A. MURRAY (Essex)
HARRY N. COMANDO
WALTER G. ALEXANDER
CHESTER I. ULMER (Gloucester)
BERTHOLD S. POLLAK (Hudson)
J. LAWRENCE EVANS
BARCLAY S. FUHRMANN (Hunterdon)
D. LEO HAGGERTY (Mercer)
L. SAMUEL SICA
RALPH J. FAULKINGHAM (Middlesex)
STANLEY NICHOLS (Monmouth)
STANLEY TESKEY (Morris)
D. W. TELLER, JR.
WILLIAM E. DODD (Ocean)
H. HALE HOLLINGSWORTH (Passaic)
HARRY F. SUTER (Salem)
FRANK L. FIELD (Somerset)
WILLIAM H. VARNEY (Warren)
FREDERIC J. QUIGLEY, Consultant
EMIL FRANKEL
WILLIAM H. MACDONALD
JOHN J. DEBUS
Guests
WALTER B. MOUNT
BYRON BLAISDELL
CHRISTIAN P. SEGARD
T. R. ROBIE
ASHER YAGUDA
S. WILLIAM KALB
WATSON B. MORRIS
ABRAHAM E. JAFFIN
J. O. HILL
ELLEN C. POTTER
NORMAN M. SCOTT
HENRY A. DAVIDSON

Chairman Johnsen called the meeting to order at 2 p. m. and introduced President Alexander, who expressed the thanks of the Society to the officers and members of the Welfare Committee for their labors during the year. Dr. Alexander urged members of The Society to contribute to the fund being raised to erect a statue to the late Dr. McBride. Dr. Sica then reported on the regional meeting of the Council on Medical Service and Public Relations which he attended in Philadephia.[1] Dr. Scott then read a report on the Veterans Care Plan.[2] He was followed by Dr. Decker, who reviewed the status of plans for graduate medical education as follows:

GRADUATE EDUCATION

Several centers will be set up throughout the state in hospital dispensaries. The general practitioner will be enabled to attend these dispensaries and during a period of three years, attending two dispensaries weekly, he will rotate through all the branches of medicine. He will spend a year in general medicine, three months in office surgery, six months in obstetrics and gynecology, three months in pediatrics and a year in the medical and surgical specialties. Medical education today is faulty in that the student is carefully prepared in college, given good training in a medical school and is then put into a hospital for internship. He has had a close contact with bed patients who are acutely ill, but until he starts to practice he has never had contact with ambulatory patients. He has never seen the beginnings of the serious illnesses.

Your committee felt that the rotating dispensary service which he will be able to obtain in this plan during the time he is practicing will add considerably to his medical education and make him a better practitioner. It will also stimulate hospital staff members, because one of the best ways to learn a subject is to have to teach it, and if a dispensary chief is charged with instruction of some of these men he will have to think a little bit harder and arrange his thoughts a little better; that, in turn, will be reflected in better care of these patients. All of this involves changes in the hospitals. The dispensary is usually placed in some unused portion of the hospital, given cast-off equipment, and is more or less submerged by the rest of the hospital. It means that hospital managers must spend money on dispensaries. It means the staff will have to spend more time there. It involves new problems in hospital administration.

While we have this plan accepted by Rutgers it is not going to be easy to put in operation. It is going to involve considerable effort and time on the part of a large group of individuals.

At the conclusion of the report, several questions were asked, which Dr. Decker answered as follows:

Q. Will they issue a diploma?

A. They will issue a certificate which carries the seal of Rutgers University and the signature of the President. None of their other extension certificates carry such validation.

1. This report appeared on page 147 of the April *Journal.*
2. This appeared on pages 217 and 218 of the May *Journal.*

Q. Who is going to finance the clinics and ward rounds?
A. The hospitals.

Q. Will Rutgers charge tuition? And if so, how much?
A. Tuition will be charged on the basis of so many dollars per credit hour.

Q. Will admission be limited?
A. Yes, at least at the start. We will admit two men each three months so that at the end of three years, twenty-four men will be attending. The first eight or ten students will be carefully selected with a view towards getting men who can criticize the program constructively. This is on the advice of Rutgers University.

MEDICAL PRACTICE

Reporting for the Subcommittee on Medical Practice, Dr. Watson Morris recommended the discontinuance of two Advisory Committees—the Committee on Auxiliary Medical Service and the Committee on Private Practice. At the same time, it was recommended that three new committees be created: committees on anesthesiology, physical therapy and radiology. These suggestions were adopted to be forwarded to the Board of Trustees.

LEGISLATION

Dr. Pollak gave the report of the Committee on Legislation which appears on page 245 of this *Journal*. Dr. Quigley amplified the part of the report which refers to the Christian Science amendment, and expressed appreciation for the coöperation of Dr. Hill, Chairman of the Public Health Committee of the Assembly of New Jersey as well as a member of our Society. On motion made by Dr. Pollak, the Committee unanimously adopted a vote of thanks to Dr. Hill.

PUBLIC HEALTH

Speaking for the Public Health Committee, Dr. Nichols reported that the N. J. Health and Sanitary Association has altered its constitution to include on its general council, representatives of the five New Jersey health professions: physicians, dentists, nurses, pharmacists and hospitals. Their constitution now calls for the first time for the participation, in their general council, of representatives of these health professions.

Dr. Nichols also called the Committee's attention to three bills before the United States Senate. One calls for more than three and a half billion dollars to control cancer; another asks for the same amount to control poliomyelitis. According to the third bill, the Government will undertake every six months to examine the urine of every person in the United States, at public expense. The reports of such analyses are to be sent both to the individual and to the State Board of Health.

Dr. Nichols also urged the county society representatives to reëstablish their county public health committees, with advisory committees in the larger counties, so that next year the county and state public health committees will go back to prewar efficiency because the job is getting heavier all the time. One item that will make the year ahead efficient is more help for everyone concerned. The time has come when every county society must have a business office with a paid secretary at least, if we are to meet all these needs and do a good job on the county level. The counties will have great difficulty on a local basis unless there is an office and staff in each county.

NUTRITION REPORT

Dr. Kalb reported on the program to disseminate information on nutrition to the public of New Jersey. One project is sponsored through the Woman's Auxiliaries in the several counties. The Public Health Committee wants the county medical societies to help activate the Auxiliaries to implement this program. The Committee has a colored film, a speaker from the Department of Agriculture, a speaker from the Red Cross who talks on food standards; and a speaker on weight reduction will be furnished directly by the Public Health Committee if requested.

Dr. Kalb also reported on the so-called "Fat-Free bread" now being widely advertised in New Jersey. The committee has had requests to pass on the desirability of this bread and the validity of their advertising. The committee made an investigation, and wrote to the baking company. Their advertising agency called to say that they saw no reason for any investigation. The committee sent for a certified copy of the bread, analysis, and then made an analysis of the breads that were bought in food stores. The results:

Per 100 Grams	Ordinary Rye	Ordinary White	So-called "Fat-free"
Moisture	35.7	36.5	33.2
Carbohydrates	53.2	51.1	50.6
Fat	0.6	1.4	1.5
Protein	9.0	9.6	10.5
Crude Fibre	0.5	0.0	1.8
Ash	1.5	1.4	2.4
Calories	46.2	45.9	46.9

The only difference was that a slice of the "Fat-free" bread was 17.4 grams and the ordinary slice of white and rye bread, 25 grams each.

The Committee wrote to the bakers to tell them that perhaps they were inaccurately advised as to the contents of their bread. Subsequently we were assured that the bakers were willing to coöperate with us by adjusting their advertising copy so that it would be accurate.

PUBLIC RELATIONS

Dr. Sica read the report of the Public Relations Committee which appeared on page 188 of the May *Journal*. He also reviewed the status, to date, of the proposed Health Congress, which is detailed on page 246 of this *Journal*.

NUTRITION IN EVERYDAY PRACTICE

S. William Kalb, M.D., Newark, N. J.
Chairman Nutrition Committee

1. *Is there an associated vitamin deficiency in diabetes?*

   In diabetes there is impairment of hepatic response to endogenous insulin and this results from protracted vitamin B complex deficiency. Intensive therapy with vitamin B complex produces striking improvement in the general health of the patient and often a marked improvement in carbohydrate metabolism. This frequently results in a reduction of insulin requirement or its elimination altogether.

2. *Can breast milk be fortified with vitamin D for infant use by giving the mother fish liver oil during pregnancy?*

   No. Vitamin D must be taken immediately after labor and during lactation (40,000 I. U. per day) in order to enrich the milk with this factor.

3. *In patients with mild depression there is an anorexia which often leads to malnutrition. Is there any therapy to stimulate their appetite?*

   The administration of amino acids not only restores the nitrogen balance but acts as a stimulant. The appetite is increased and the patient's equilibrium and energy approaches normal. Give Elixir of Aminoacetic Acid (Glycine) 4 to 6 Grams a day in divided doses for 4 to 12 weeks.

4. *Why do peptic ulcer patients need thiamin?*

   The increased thiamin requirement is due to the antacid medication which these patients take and which reduces activity of the B complex.

5. *Since sugar is still being rationed, what substitutes can be used in diets?*

   Honey, molasses, Karo syrup, maple syrup, preserves, jellies, prepared puddings, candy, and canned fruits.

6. *Is there a simple method of calculating the insulin requirement in a diabetic?*

   Yes. Take a fasting blood sugar and subtract 100 from the result and then divide by 5. This will give you the total number of units per day. Example:

Fasting blood sugar	250
minus	100
Divide by 5)	150

   30 units of regular insulin per day

7. *What are the signs and symptoms of hyperinsulinism?*

   Tachycardia, sweating, tremor, elevation of blood pressure, pallor, fear, mild dyspnea, severe abdominal pain.

8. *Are clams nutritious?*

   Raw clams contain a thiamin destroying factor and are not nutritious. Cooked clams permit relative stability of thiamin and are nutritious.

SUBCOMMITTEE ON LEGISLATION

Dr. Pollak reported to the Welfare Committee on March 31, 1946, that all pending bills introduced into the State Legislature having public or individual health implications had been reviewed by his committee. The status of major bills follows:

Senate 95, upon motion by Mr. Stanger, its sponsor, was withdrawn March 25. The fact that this bill is apparently dead is attributable in great measure to the excellent work done by Legislative Keymen, County Society Officers and the membership at large, especially the veterans in the various County Societies. This measure had sentimental and political appeal, and to have accomplished its defeat, thus preserving the high standards of our Medical Practice Act, is a legitimate cause for satisfaction.

Assembly 45, which was referred to the Judiciary Committee February 11, has remained there. If it is moved to third reading, we are satisfied that it cannot muster enough strength for passage.

Assembly 47, by Mr. Jones, reorganizing the State Department of Health. A hearing on this measure was held February 4, at which a large number of groups and organizations were heard. Prior to the hearing representatives of the Committees on Legislation and Public Health held a meeting and went over the bill section by section, and tentatively agreed upon certain recommendations as to changes. Subsequently the bill was considered section by section by the Conference of Allied Medical Professions, and suggested changes were agreed upon.

The Executive Secretary of the Committee presented a statement incorporating recommendations as to amending the bill. The major proposal was that the Public Health Council, which, according to the terms of the bill, was to consist of seven members with no special qualifications, be increased from seven to nine members and be composed as follows: two physicians, one dentist, one pharmacist, one nurse, one veterinarian, one sanitary engineer and two others. In support of this, we presented a reasoned argument for the necessity of having the Council composed of individuals who had health or sanitary education and experience.

The ten women's organizations seemed to be interested in just two questions: (1) that the provision as to the Council remain as proposed in that bill, rather than represent "special interests"; (2) that the qualifications for the Commissioner of Health be increased so as to provide that the appointee, in addition to having an M.D. degree and public health experience, must hold the degree of Doctor of Public Health or have had additional post-graduate training.

The official copy reprint of A-47 provides that *two of the seven members composing the Public Health Council shall be physicians.* There is no change in the qualifications for the Health Commissioner.

The Speaker of the House, Mr. Jones, who was the sponsor of this measure, asked the President of the State Board of Health, Dr. Frederick P. Lee, and the Executive Secretary of this Committee, to consider a "Christian Science amendment" which had been proposed by the legislative agent of that group. A memorandum with respect to this amendment was sent to Mr. Jones and copies have been sent since to all members of the Legislature and to all members of our Society's Welfare Committee. A reading of this will show the utter preposterousness of the proposal. The health officers of the State and several other groups are not at all satisfied with A-47 and there is some question as to whether the bill will muster enough votes for passage.

Assembly Concurrent Resolution 3, reported on page 148 of our April *Journal,* authorized the Commission on Post-War Economic Welfare to report on proposed sickness insurance for employees. A hearing on this resolution was held March 8. In conformity with the action of the House of Delegates of the A. M. A. the Executive Secretary of this Committee presented a prepared statement in support of the principle of cash sickness benefits, stressing the desirability of utilizing and extending present voluntary cash sickness plans now in operation in this state, and making it obligatory upon all employers to make available to their employees a sick benefit plan containing minimum standards; the scheme to operate somewhat similarly to that of Workmen's Compensation.

The Editor, Dr. Davidson, in his capacity as Secretary of the Committee on Public Relations, attended this hearing and reported it in the April *Journal,* including an abstract of our statement. (See page 148.)

Assembly 133, which we disapproved, would forbid Boards of Education and other agencies to discriminate as to reports by optometrists and physicians who are eye specialists. This bill is still in the Public Health Committee.

Assembly 91 and Assembly 183, the bills to create a board of chiropractic examiners and

a board of naturopathic examiners, respectively, are in the Public Health Committee, where we feel quite certain they will remain.

Assembly 171, which is disapproved, would provide for the establishment of four cancer clinics to be operated by the State Department of Health, has been reported out of committee, *without recommendation.* We doubt that this measure will command enough support for passage.

A HEALTH CONGRESS FOR NEW JERSEY

Representatives of the health professions and some of the consumer organizations met at the Home of The Medical Society of New Jersey on March 24th to consider desirability of forming a State Health Congress. It was the consensus of those present that there would be value in such an organization provided it included representatives of the public which consumes medical service as well as of the health professions which render such service. While there are many health agencies in New Jersey, there is no organization which focuses squarely on the distribution of health care, nor does any existing group unite both the producers and consumers of these services. To avoid duplicating the work of other organizations, it was felt that the immediate problem on which such an organization could concentrate would be the distribution of health services in all their aspects.

It was agreed that the organization should be formed by representatives of the groups which appeared at the original meeting, namely:

1. The Medical Society of New Jersey
2. State Dental Society
3. New Jersey Pharmaceutical Association
4. American Legion
5. State C. I. O.
6. New Jersey Hospital Association
7. New Jersey Department of Health
8. State Department of Institutions and Agencies
9. New Jersey Health and Sanitary Association

with the addition of representatives from:

10. State Grange
11. State Federation of Labor
12. The State Chamber of Commerce

The Medical Society will issue a call for representatives of all these groups to meet at the Headquarters of the Society, 315 West State Street, Trenton, at 3:00 p.m., Sunday, April 14th. It is contemplated that temporary officers will then be elected and a committee named to draw up an organizational structure. Among the possibilities to be considered are: (a) Small continuing body of a few representatives from each organization to meet frequently and to maintain a permanent secretariat; (b) loosely organized federation of representatives of these organizations meeting two or three times a year or on call; or (c) an occasional, perhaps annual, meeting of the general membership of all of the constituent organizations.

A question has been raised as to whether the new agency should adopt principles of sound health care before forming an organizational structure or whether the reverse order would be more logical. It was the opinion of most of the personnel present on March 24th that the organizational structure should come first.

It is not contemplated that the new organization would engage in elaborate surveys of health needs nor would it cover any of the purely technical aspects of health care since both these functions are already well served by existing agencies. It was rather the thought that by utilizing services already available, the new organization might (1) establish principles to assure a better distribution of all health services to the people in New Jersey; (2) adopt recommendations to implement these principles and (3) use whatever machinery was at its disposal to inform the public of its findings and recommendations.

On April 14, the next meeting was held. Present were the following representatives from the indicated organizations:

The Medical Society of New Jersey: Drs. Alexander, Sica, Nichols and Davidson

N. J. Health and Sanitary Association: Dr. Blaisdell and Mr. Hall

State Department of Health: Dr. Snegireff and Mr. MacDonald

N. J. Pharmaceutical Association: Mr. Debus

N. J. Council of the C. I. O.: Miss Jean Henry

N. J. Department, American Legion: Mr. Laurencelle

N. J. Hospital Association: Dr. Emil Frankel

N. J. State Dental Society: Dr. John Carr

State Dept. of Institutions and Agencies: Dr. Ellen Potter

Chamber of Commerce: Dr. E. F. Purcell

N. J. State Nurses' Association: Mrs. Martin and Miss Brunner

Also invited but not present: representatives of the State Grange and State Federation of Labor.

Mr. Hall reported that the State Health and Sanitary Association felt that if the proposed Congress were concerned primarily with problems of the distribution of individual medical care, it would not conflict with or overlap the work of the Health and Sanitary Association which was focused especially on *public* health, and that accordingly his organization would participate in the proposed State Health Congress.

Dr. Frankel and Dr. Potter reported that the Department of Institutions and Agencies was in favor of any project aiming at improving health.

Dr. Carr reported that the officers of the State Dental Society were prepared to endorse the proposed Congress.

Mr. Laurencelle announced that the American Legion had never allied itself with any other group because of the specialized nature of its program. The Legion pledged its cooperation but could not participate actively in a program that sought to influence legislation except when the action touched on veterans' problems; and in those cases would be bound by American Legion's basic policies.

Dr. Purcell reported that the Chamber of Commerce had not decided what point of view to take towards the proposed Congress.

Miss Henry explained that the C. I. O. had its own legislative program and could not commit itself to participating in any other organization's total program without examining each proposal on its own merits. However, the C. I. O. saw the value of the interchange of ideas through such an organization and would participate to that extent, provided it did not put itself in the position of appearing to endorse legislation or oppose legislation inconsistent with C. I. O. policies.

Mr. Debus notified the meeting that the N. J. Pharmaceutical Association was prepared to go along with such a Congress.

Dr. Snegireff reported that while the Commissioner of Health was keenly interested, he could not commit the Department in advance.

Mr. Hall favored the organization's limiting itself to problems concerning the distribution of *individual* medical care, feeling that if it embraced such problems as industrial hygiene and sanitation it would overlap the work of the Health and Sanitary Association.

Miss Henry moved that a temporary organization be created and a committee formed to draft a constitution and by-laws. Motion carried.

Dr. Sica nominated Dr. Nichols for temporary president. No other nominations were made and Dr. Nichols was declared elected.

Dr. Davidson nominated Mr. Hall for temporary secretary. There being no other nominations, Mr. Hall was declared elected.

DO YOU NEED AN OFFICE ASSOCIATE?

To give further service to the medical profession, The Medical Society of New Jersey is planning a clearing house of information about doctors who want office assistants or associates and to assemble names of practitioners who are looking for just such an opportunity.

If you are interested in placing in your office a physician to serve as associate or assistant, please send in to the Executive Offices (315 West State Street, Trenton 8) the following data: (a) Your name and address, (b) your specialty, (c) approximate age bracket of the assistant or associate desired, (d) special requirements as to training or experience, (e) financial arrangements you are contemplating, (f) personal or other requirements.

Any physician-reader who is interested in obtaining placement as an office assistant or associate is requested to send to the Executive Offices (315 West State Street, Trenton 8) the following data: (a) Name and mailing address, (b) date of birth, (c) Medical School and year of graduation, (d) states in which licensed, (e) Army, Navy or U. S. P. H. S. experience, (f) professional training and experience, include board diplomas held, if any, graduate courses, and residencies, (g) whether you want association with a general practitioner or specialist, and if the latter, what specialty, and (h) part of the state or type of community preferred.

SUPPLEMENTARY LIST NO. 2
THE MEDICAL SOCIETY OF NEW JERSEY

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

Adler, Joseph, 933 Avenue C, Bayonne (9)
Annunziata, Augustine, 210 Central av., Orange (7)
Bauch, Solomon, 564 Hawthorne av., Newark (7)
Bayer, Harold J., 1616 Pacific av., Atlantic City (1)
Benz, George L., 32 W. Market st., Newark (7)
Bird, Ivan F., N. J. State Hospital, Trenton (11)
Boylan, Matthew E., 569 Pavonia av., Jersey City (9)
Brock, Howard F., 417 W. Broad st., Westfield (20)
Brodkin, Louis A., 872 Chancellor av., Irvington (7)
Brown, Edith L., 340 Garfield av., Avon (13)
Burnett, Hayes J., 1 Hawthorne pl., Montclair (7)
Chapman, Ellis J., 203 Danforth av., Jersey City (9)
Christensen, Osborne D., 345 Summit av.,H'ck's'k(2)
Cohen, Herman, 489 Jersey av., Jersey City (9)
Connolly, Thomas W., 921 Bergen av., Jersey City(9)
Conte, Andrew N., 1018 S. Broad st., Trenton (11)
Craster, Charles V., Plane & William sts., Newark(7)
Cufari, Carmine J., 725 18th st., Union City (9)
Daly, Edmund J., 921 Bergen av., Jersey City (9)
Davidson, Eric W., 295 Montgomery st., Bloomf'd(7)
Dayton, Spencer T., 86 W.Demarest av.,Englew'd(2)
Decker, John G., 216 Boulevard, Hasbrouck Hts. (2)
Dennison, Alfred D. J., 601 Ridgew'd rd.,Maplew'd(7)
DePietro, Vincent P., 520 48th st., Union City (9)
DeRosa, Louis, 193 Danforth av., Jersey City (9)
DiMarino, Anthony J., 735 Delaware st.,Paulsboro(8)
Donnelly, Joseph P., 58 Kensington av.,JerseyCity(9)
Farb, Harry H., 21 Clinton pl., Newark (7)
Felitti, Vincent J., 435 79th st., North Bergen (9)
Ferenchak. Ralph, 219 Martine av., N. Fanwood(20)
Finn, Frederick A., 921 Bergen av.,.Jersey City (9)
Flichtenfeld, Morris, 283 Fourth st., Jersey City (9)
Foote, Sherman K., Clinton av., Wyckoff (16)
Furst, William, 188 Clinton av., Newark (7)
Galotta, Margaret, 533 Prospect av., Hackensack (2)
Garber, Robert S., N. J. State Hospital, Trenton (11)
Gehl, Raymond H., 65 Wolcott ter., Newark (7)
Gibson, Augustus, Mendham (7)
Gittlesohn, Isador, 700Kind'rkam'k rd.,RiverEdge(2)
Gleeson, William J., 640 Bergen av., Jersey City (9)
Glover, Lawrence L., 53 Kings Hwy W., Had'nf'd(4)
Gordon, Norman W., 121 Third st., Elizabeth (20)
Granger, James R., 235 Spring st., Trenton (11)
Greenwald, Eugene, 100 Hollywood av., Hillside (7)
Haggerty, Francis F., 724 Hudson st., Hoboken (9)
Haines, Keith E., B'way Stevens Bldg., Camden (4)
Harris, Sidney, 301 W. Fifth av., Roselle (20)
Harris, William G., Main st., Mullica Hill (8)
Hely, Charles J., Jr., 2424 Central av., Westfield (20)
Horner, John I., 137 W. Kings H'way, Audubon (4)
Horowitz, Leo, 3644 Boulevard, Jersey City (9)
Jacobs, Benjamin, 1612 Clinton pl., Hillisde (7)
Jarecki, Max, 905 Bergh st., Asbury Park (13)
Kelley, Charles B. P., 336 Engle st., Tenafly (2)
Kennedy, John N., 831 Madison av., Plainfield (20)
Krasnitz, Alexander, Fairview San., New Lisbon (3)
Krohn, Marc, Campbell av., Belford (13)
Lane, Milton, 982 Stuyvesant av., Union (20)
Lapin, Mathew R., 628 W. State st., Trenton (11)
Levitas, George M., 199 Fairview av., Westwood (2)
Little, Rufus R., Bergen Pines Hospital, Oradell (2)
Luce, Henry A., 12 Mt. Vernon av., W. Orange (7)
Lueddecke, Roland E., 216 Rand'lph av.,E.R'th'f'd(2)
Lussier, George H., N. J. State Hosp., Marlboro (3)
Lustig, Melvin, 137 Lyons av., Newark (7)
Lynch, James F., 1947 Boulevard, Jersey City (9)
Maffeo, Carl E., 149 Van Buren st., Newark (7)
Malinowski, John, 554½ Jersey av., Jersey City (9)
Mangelsdorff, Arthur F., Martinsville (18)
Manno, Peter D., 81 W. 25th st., Bayonne (9)
Marchigiano, Michael A., 492 Ferry st., Newark (7)
Margolin, Samuel J., 1012 80th st., N. Bergen (9)
Markowitz, Benjamin B., 116 Gifford av., Jer.City(9)
Martland, Harrison S., Newark City Hosp.,N'w'k(7)
McNeely, Julia A., 117 Washington st., E. Orange(7)
Moore, J. Leonard, 38 Alexander st., Princeton (11)
Moore, John P., 16 Richmond st., Newark (7)
Morris, David G., 11 W. 26th st., Bayonne (9)
Motzenbecker, Wm. J., 16 Milford av., Newark (7)
Nalitt, David I., 28 W. 33rd st., Bayonne (9)
Nelson, Francis B., 275 Orchard st., Westfield (20)
Newman, Abraham J., 132 Manhattan av.,Jer.City(9)
O'Gorman, Michael W., 46 Mercer st., Jersey City(9)
O'Hanlon, George, Medical Center, Jersey City (9)
Palmisano, Vincent S., 13 W. 6th av., Runnemede(4)
Pellecchia, Leonard J., 109 Parker st., Newark (7)
Pentel, Louis S., 307 60th st., West New York (9)
Peters, Edgar A. P., 394 Bergen av., Jersey City (9)
Pindar, William A., 7523 Broadway, N. Bergen (9)
Pyle, Louis A., 89 Fairview av., Jersey City (9)
Rampond, James R., 579 Springdale av.,E.Orange(7)
Reingold, Alexander, 221 Garden st., Hoboken (9)
Ricciardelli, Emmanuel F., 1670 Blvd., JerseyCity(9)
Richardson, Arthur H., 60 Orange rd., Montclair (7)
Richlan, Alfred, 173 Third st., Newark (7)
Rooks, Wendell H., Wyckoff (2)
Rosen, Frank L., 33 Johnson av., Newark (7)
Ruoff, Andrew C., III, 4500 Blvd., Union City (9)
Sauerbrunn, Bertram J. L., 681 New'k av., Eliz'h(20)
Scala, Hugh A., 41 Madison av., Jersey City (9)
Scanlan, David B., 15 S. Illinois av., Atlantic City(1)
Scheer, Eli, 895 Queen Anne rd., Teaneck (2)
Schulman, Abraham S., 4518 Blvd., Union City (9)
Schorr, Herman E., 26 Lincoln Pkwy., Bayonne (9)
Sciorsci, Edward F., 609 Bloomfield st., Hoboken (9)
Seidmon, Edward E., 221 W. 7th st., Plainfield (20)
Sena, Dominic R., 1554 Irving st., Rahway (20)
Speer, Charles A., 19 Holly st., Cranford (20)
Sperling, Walter, 729 Oxford st., Montclair (7)
Stein, Frederick, 620 Ridge rd., Lyndhurst (2)
Stone, Russell, 56 Summit st., Phillipsburg (21)
Straus, Walter, 1239 Greenwood av., Trenton (11)

Tomaiuoli, Michele, 19 76th st., Woolcliff (9)
Toscanno, George A., 305 Union st., Hackensack (2)
Tsucalas, James C., 753 Montgomery st., Jer.City(9)
Tucker, Albert B., 47 Lincoln Park, Newark (7)
Urban, Lawrence J., 679 Avenue C, Bayonne (9)
Verdon, Robert E., 682 Anderson av., Cliffside (2)
Wescoat, Geo. N. A., 202 W. Main st., Moorest'n (3)
White, Hugh M., 901 Summit av., Jersey City (9)
Willner, Milton, 225 Renner av., Newark (7)
Wilson, Isam E., 110 Chapel av., Merchantville (4)
Wortman, Herbert McC., M't'nside Hosp., Mtclr. (7)
Zdanowicz, Stefan J., Hackettstown (21)
Zucker, Isadore, 688 Clinton av., Newark (7)

ASSOCIATE MEMBERS

Bradley, Muriel J., 284 Highland av., Up. M'tclair(7)
Crecca, Joseph V., 376 Roseville av., Newark (7)
Culver, Perry, 413 Mt. Prospect av., Newark (7)
Edwards, Sydney K., 52 Lexington dr.,Livingston(7)
Fain, Irving, 155 Chancellor av., Newark (7)
Gaydos, Albert, 225 Hillside av., Nutley (7)
Hyde, Robert T., 46 Maple st., Millburn (7)
Insabella, John, 317 So. Orange av., Newark (7)
Keyssar, Alexander, 18 Isabella av., Newark (7)
Leon, Maurice J., 183 Grove st., Montclair (7)
Livingston, Elias, 591 Stuyvesant av., Irvington (7)
Modny, Michael T., 262 Ridgew'd av., Glen Ridge (7)
Sarno, Anthony, 130 Parker st., Newark (7)
Shapiro, Sydney H., 334 Union st., Irvington (7)
Sparks, Spurgeon, Jr., 2100 Oakwood av., Orange (7)
Travers, Frank A., 485 Park av., Orange (7)

OBITUARIES

ALEXANDER KLEIN, M.D.

Dr. Alexander Klein, who practiced medicine in Perth Amboy for almost a quarter of a century, died suddenly on May 23 while attending a patient. Dr. Klein was born in Hungary in 1889 and practiced medicine in that country from 1919 to 1922, when he came to the United States. He moved to Perth Amboy in 1923 and became Assistant Surgeon to the Perth Amboy General Hospital.

CHARLES H. LYON, M.D.

Dr. Charles H. Lyon, former president of the Warren County Medical Society, one-time chief physician at the Bachman Memorial Hospital in Shanghai, China, and a practicing physician for the last 27 years, died in Phillipsburg on April 19, at the age of 72.

Born in China, the son of missionaries, Dr. Lyon was graduated from the University of Pennsylvania Medical School in 1898, and went to the hospital in China, operated by the Board of Foreign Missions of the Presbyterian Church, two years later. He specialized in surgery.

He returned to this country in 1918 and, after a course at Wills Eye Hospital in Philadelphia, established an office in Phillipsburg. He was an elder in the Presbyterian Church and served as a captain in the Medical Corps during the First World War, and during the recent war served as chief medical examiner for the Warren County Selective Service Board.

THOMAS P. PROUT, M.D.

New Jersey lost one of its senior psychiatrists on April 26, 1946, when Dr. Thomas P. Prout, founder and director of the Fair Oaks Sanatorium in Summit, died there at the age of 78. Born in Ashland, N. Y., Dr. Prout was graduated in 1891 from the College of Physicians and Surgeons, Columbia University. His basic training was in pathology and he entered the state hospital system in 1893 as a pathologist. After eight years in this specialty he studied abroad for a year and returned to New Jersey to establish Fair Oaks. Dr. Prout was at one time president of the Union County Medical Society and subsequently became president of the New Jersey Neuropsychiatric Association.

SURVIVORS' INSURANCE

Physicians in attendance at deaths are often in a position to remind the widow or dependent children that there may be a survivors' benefit payable under social security legislation. The government is anxious to pay all such claims but cannot pay them unless application is made. Many widows do not realize that they are entitled to benefits under the law. One reason is a confusion between unemployment compensation and survivors' insurance. To set the record straight, the following tabulation has been prepared by the local office of the Social Security Board:

The misunderstanding is due chiefly to the basic similarities of the program; both are part of the same "family security" since both promote the "social security" of workers and their families. The following list shows the essential differences between the two insurances in New Jersey:

	FEDERAL OLD-AGE AND SURVIVORS INSURANCE	NEW JERSEY STATE UNEMPLOYMENT COMPENSATION
PURPOSE	To protect workers and their families against loss of income because of old-age or death of the worker.	To protect workers against loss of income because of unemployment.
COVERAGE	Workers for employers who have one or more employees at any time in stores, offices, factories, industrial or commercial jobs.	In general, workers in the kinds of jobs covered by the OASI program, except that the employer must have had four or more employees in at least 20 weeks during the year.
BENEFITS	Benefits are paid monthly and are of two major kinds: (1) RETIREMENT BENEFITS for the insured worker himself after he reaches 65; his wife when she is 65; his children until they are 16 or 18 if still in school. (2) SURVIVORS PAYMENTS WHEN AN INSURED WORKER DIES, for his widow and their children under 16 or 18, if still in school, his widow when she reaches 65, his dependent parents at age 65 if he has left no widow or young child. In some cases a lump sum is payable.	Benefits are paid to workers who have lost their jobs or who are partly unemployed through no fault of their own, if they have had sufficient previous earnings, provided they meet the requirements of the State law. They must be able and available for work, and benefits are not paid if unemployment is due to illness. See page 148 of the April issue of this *Journal*.
AMOUNT OF BENEFITS	Size of payments depend on worker's average monthly wage. The minimum benefit is $10 and maximum is $85 per month. Benefits are payable as long as conditions of the law continue to be met and not for any specified number of months or years.	Size of payments depend upon the amount of wages the worker had earned on covered jobs. The minimum benefit is $9 per payment, and the maximum is $22. The maximum number of payments is 26 in a benefit year.
HOW BENEFITS ARE PAID FOR	Both workers and employers share the cost. The employer takes 1 cent from each dollar of a worker's pay, adds an equal amount and sends the total to the Federal Government. Only the first $3,000 of a worker's wages with each employer are taxable.	Employers and workers pay taxes on the first $3,000 of a worker's wages. Workers pay 1% of their wages and employers pay at a rate determined by the New Jersey Unemployment Compensation Commission on the basis of their benefit experience. It varies from 0.9% to 3.6% of wages paid.
APPLICATION FOR BENEFITS	Application should be made in person or by mail at the field office of the Social Security Board. Look in the telephone book under Federal Security Agency, Social Security Board.	Benefits must be claimed by the unemployed worker at a local office of the United States Employment Service. At the same time he must also apply for work.

The following do *not* come under these insurances: farm workers, government employees, domestics, employees of certain nonprofit agencies and self-employed persons. (The latter includes most private medical practitioners who, being self-employed, are not covered.)

For further information apply to Social Security Board, Post Office Building, Trenton 9; or to Federal Security Agency, 45 Branford Place, Newark 2.

FAMILY BENEFITS UNDER THE SOCIAL SECURITY ACT

A great many people are not aware when they pay social security taxes that they are paying not only for old-age but also for survivors' protection. The result is that some who are entitled to benefits on account of old-age and survivors' insurance put in no claim; or else they delay putting in their claim, with a consequent loss of benefits.

The Social Security Board is eager that workers and their families get all they are entitled to. It therefore asks ministers, doctors, social workers, personnel managers, funeral directors, and all others who come in contact with families of deceased workers to suggest to the survivors that they get in touch with the local office of the Social Security Board. They may be entitled to benefits.

Under the law survivors are eligible for certain benefits if the deceased breadwinner died "currently" insured, and for certain other benefits besides if he died "fully" insured. To be "fully" insured, a worker must have been employed in covered work—in private business or industry, that is—for at least half the period between January 1, 1937, when the program began, and the time of his death (or half the period since he became 21, if that was at a later date). To be "currently" insured, a worker must have been employed in covered work for at least half the last three years.

Monthly benefits are payable to the following survivors of "fully" insured workers:

1. *Children.* These receive monthly payments until they are 16—or 18 if still at school.

2. *Widow with children under her care.* Provided she does not remarry, she receives monthly payments until her youngest child is 18. The payments stop then, but begin again when the widow is 65 and continue until death.

3. *Widow without children under her care.* She receives monthly payments when she reaches the age of 65.

4. *Dependent parents.* Provided the deceased worker left neither widow, nor child under 18, dependent parents receive monthly payments when they reach the age of 65.

Monthly benefits are payable to the following survivors of "currently" insured workers:

1. *Children.* These receive monthly payments until they are 16—or 18 if still at school.

2. *Widow with children under her care.* Provided she does not remarry, she receives monthly payments until her youngest child is 18.

Lump-sum death benefits are payable in the case of either "fully" or "currently" insured workers as follows:

1. *Near relative or person who paid the funeral expenses.* If the deceased worker leaves no one immediately entitled to monthly benefit payments, then a lump-sum death payment is made to the widow, child, grandchild, or parents.

In order that no payments may be lost, claims for benefits should be filed immediately after the insured worker's death. Monthly payments to survivors are retroactive, but for not more than three months prior to the month of filing. Thus if a claim is not filed until the fourth month after the month of the insured worker's death, one month's payment is lost.

BOOK REVIEW

Shock Treatment and Other Somatic Procedures in Psychiatry. L. B. Kalinowsky, M.D., and Paul Hoch, M.D. Grune & Stratton, New York. 1946. ($4.50.) (294 pages.)

Shock treatment represents the most dramatic—and most hopeful—note introduced into major psychiatry this century. Given an appreciable boost by war experience (and incidentally by the movies), convulsive therapy seems to be as much demanded in psychiatry as penicillin and the sulfa drugs are in medicine and surgery. Our knowledge of shock technics, however, has grown piecemeal and until the Jessner and Ryan text in 1941 there was no manual to which the practitioner could turn for orientation in this new field. Unfortunately, the Jessner-Ryan book was released at the dawn of electric convulsion technics so that it soon became obsolete except for psychiatrists who preferred insulin or metrazol.

Kalinowsky and Hoch now provide us with a comprehensive manual which brings together in one convenient place and in compact form all the important information needed to appraise and administer shock treatments. In systematic order they review the selection of patients, the technic of administration, the complications, indications, contra-indications, and reported results of insulin shock, metrazol convulsive therapy, electric shock treatment and combined therapies.

Mention is made of fever therapy, narcosynthesis, refrigeration and prefrontal lobotomy, but these "other somatic procedures" are treated in too sketchy a fashion to be useful to the reader. Some eight different "somatic procedures" are compressed into 28 pages. The book closes with an interesting review of the theoretical aspects of shock therapy. It is a valuable source of information for the general practitioner, a guide for the internist whose advice is so often asked on problems of contra-indication, and a practical handbook for the psychiatric therapist.

HENRY A. DAVIDSON, M.D.

COUNTY SOCIETY REPORTS

BERGEN COUNTY

H. E. Reinhold, M.D., Reporter

Regular meeting of the *Bergen County Medical Society* was held at Bergen Pines Hospital, Oradell, on March 12th, 1945, and was called to order by the President, Dr. Frederick G. Dilger.

The Secretary brought to the attention of the members the fact that the Hill-Burton Bill (S-191), which was recently passed by the Senate as amended by organized medicine, is before the House of Representatives for hearing now. Since this Bill is favorably received by organized medicine, all members were asked to urge their Congressmen to support the measure.

Dr. Samuel Alexander made a motion that the Secretary be directed to send a letter to Congressmen Towe and Thomas on behalf of the Bergen County Medical Society, favoring the passage of this Bill (S-191).

The following were elected to membership: Dr. Rufus R. Little, Ridgewood; Dr. Gerald J. Dolan, Hillsdale; Dr. James C. Wren, Closter; Dr. James S. Breschia, Waldwick; Dr. Everett C. Ravits, Hackensack; Dr. Salvatore V. Dallio, Lodi, and Dr Alfred R. Wollack, Park Ridge.

Speaker of the evening was Dr. George Anopol, Professor of Orthopedic Surgery, New York Post Graduate Medical School, who spoke on "Leg Lengthening" with special reference to his own technic. He demonstrated by slides, lecture, and plaster cast model, his method of lengthening the tibia in polio and other conditions where shortening is present. The leg should be lengthened 1/32nd of an inch twice a day and must be kept elevated above the heart level at all times to assure adequate return circulation. If this is observed, thrombosis of the arteries and damage to the peripheral nerves can be avoided. Average lengthening in the author's series has been 2¾ inches.

Regular meeting of the *Bergen County Medical Society* was held at Bergen Pines Hospital, Oradell, on April 9th, 1946, and was called to order by the President, Dr. Frederick G. Dilger.

The following were advanced from associate to regular membership: Dr. Frederick Stein of Lyndhurst, Dr. Joseph D. Cuono of Palisade and Dr. Sidney Franklin of Englewood.

Elected to membership were: Dr. James Brennan of Fairlawn, Dr. Eli Scheer of Teaneck, Dr. J. John Kristal of Hackensack, Dr. Eugene A. Andrick of Hohokus, Dr. Kenneth M. Delafrange of Westwood, Dr. Winston H. Johnson of Hackensack, Dr. Charles S. Kollar of Ridgewood, Dr. Russell B. Grant of Hackensack, Dr. Vincent A. Scialli of Paramus, Dr. Windel Silverman of Rutherford and Dr. Harry Rhodes, Jr., of Hasbrouck Heights.

Essayist of the evening was Dr. Irving Wright, Clinical Professor of Medicine, Cornell University Medical School, who spoke on "Use of Dicoumarol in Coronary Thrombosis".

Dr. Wright first used dicoumarol in the treatment of thrombophlebitis with marked success. It stopped propagation of the thrombus and prevented other thrombi from forming. This suggested its possible use in the treatment of coronary thrombosis. Since 1942, he has used it on 80 severe and complicated cases. Conventional treatment of rest and oxygen were also used. Dicoumarol was also given by mouth, 300 mg. daily in single doses until the prothrombin time reached 30 seconds, then the daily dose was cut down to 100 mg. more or less until the prothrombin time reached five seconds, when the drug is completely discontinued. When the prothrombin time descends to 30 seconds, 300 mg. daily are again given.

The speaker stressed the importance of taking daily prothrombin time and consulting the laboratory report before administernig each dose. When hemorrhagic accidents occurred, large doses of vitamin K are administered parenterally. Where massive hemorrhages occur, one or two whole blood transfusions of fresh blood usually suffice. The regime was continued for thirty days after the last coronary episode occurred.

Of the 80 patients, 15 died. No death resulted from dicoumarol as such.

BURLINGTON COUNTY

T. B. Dickson, M.D., Reporter

Regular monthly meeting of the *Burlington County Medical Society* was held at the Burlington County Hosptial, Mount Holly, on April 11, 1946. In the absence of Dr. Summey, the president, Dr. William Bray, the president-elect, presided. Dr. R. Haldeman of Mount Holly was elected to the Nominating Committee of the County Society to take the place of Dr. Daniel Remer, whose term expired in 1945. Dr. Charles S. Mills, who was operated on in April, is now home and convalescing.

Dr. George Wescoat of Moorestown and Dr. Alexander Krasnitz of New Lisbon were elected to membership in the Burlington County Society.

Dr. S. E. Stokes introduced the speaker of the evening, Lt. Col. Edward Zukauckas, who talked on *The General Practitioner and Public Health.* The essayist touched on vital statistics, laboratory services, communicable diseases, maternal and child health, public health nursing, venereal disease problems, sanitation services and public health education. He discussed the problem of mosquito control in New Jersey highlighted by the return of many veterans from malarial areas throughout the world. Colonel Zukauckas pointed out a possible danger in the short treatment for gonorrhea with penicillin—the hazard being that it might mask the initial chancre of syphilis.

In opening the discussion, Dr. Stokes asked what public health features were practical in a rural county like Burlington. Colonel Zukauckas answered that a survey was first needed and that probably an assessment of only a dollar per capita would be sufficient to implement a comprehensive health program.

CAMDEN COUNTY

Joseph C. Lovett, M.D., Reporter

A meeting of the *Camden County Medical Society* was held April 2, 1946, at the Camden City Dispensary with DR. HENRY B. DECKER, President, presiding. Sixty members were present.

DR. JOSEPH NEWMEYER and DR. JAMES HARBESON III were introduced to the Society. Applications for membership were received from DR. FRANCESCO D'IMPERIO and DR. H. EDWARD YASKIN. Proposals for honorary membership of DR. EDWARD W. ROSSELL and DR. WILLIAM MARTIN were read.

The speaker of the evening, DR. J. Q. GRIFFITH, JR., Director of the University of Pennsylvania Labcratory for the Study of Hypertension, was introduced by DR. T. B. LEE. Dr. Griffith gave an instructive and interesting talk on *Medical Treatment of High Blood Pressure.* Dr. Griffith stated that we may have high pressure with low capillary pressure. Factors causing hypertension are renal, pituitary, adrenal, increased capillary fragility and miscellaneous. Treatment was outlined in each case.

JUDGE JOHN B. KATES, Chairman of the Camden County Committee to raise funds for the American Cancer Society, asked for the financial support of the physicians. Sixty per cent of the money will be used in the county.

DR. JOHN BRENNAN of the Nominating Committee proposed DR. H. WESLEY JACK as alternate to the Nominating Committee of the State Society. This was approved.

DR. DAVID BENTLEY of the Executive Committee announced the dropping of two members for the non-payment of dues for three years.

DR. T. B. LEE reported for the Centennial Committee that the hundredth anniversary of the Society will be celebrated in November 1946.

DR. KEITH E. HAINES and DR. VINCENT S. PALMISANO were elected to membership in the Society.

DR. T. B. LEE submitted amendments to the Constitution and By-Laws of the Society.

The Society of the Honorary Consultants to the Army Medical Library wrote urging us to request our Congressmen to support the bill to provide an adequate building for the Army Medical Library in Washington. A motion to that effect was seconded and passed.

CAPE MAY COUNTY

C. W. Way, M.D., Reporter

Annual Meeting of the *Cape May County Medical Society* was held at Fred's Restaurant, Cape May Court House on May 7 at 9 p.m. with PRESIDENT GEORGE M. BROOKS presiding. The following officers were elected for the coming year: President, DR. S. J. D. EISENHOWER, Wildwood; Vice-President, DR. ALEXANDER MOON, Cape May City; Secretary, DR. C. W. WAY, Sea Isle City; Treasurer, DR. HAROLD HUGHES, Cape May City; Reporter, DR. C. W. WAY.

DR. C. W. WAY was elected to the Nominating Committee of the State Medical Society. Annual delegates to the State Medical Society are DR. HERSCHEL PETTIT, Ocean City; DR. GEORGE DANDOIS, Wildwood; and DR. C. W. WAY, Sea Isle City.

MAJOR MILLARD CRYDER, Cape May Court House, was welcomed to his first meeting since returning from the Armed Forces. DR. FRANK HUGHES, Cape May City, who had been confined to a hospital in St. Louis, Mo., and then to his home in Cape May City for the past eight months due to an automobile accident, attended his first meeting in that time and was extended a royal welcome. He is the oldest member of the Cape May County Medical Society.

The Society went on record as endorsing the new Tomlin Memorial Hospital and pledging their medical support. The entire Society will be entertained as the guests of the Hospital Foundation at the Wildwood Country Club on June 4, 1946.

DR. LEOPOLD J. SCHWARZ, Wildwood, and DR. JOHN A. MOIR, Cape May Court Hourse, were elected to membership. The president appointed DR. MAURICE COHEN, Wildwood; DR. MILLARD CRYDER, Cape May Court House, and DR. F. B. LANE HAINES, Ocean City, a committee to revise and rewrite the by-laws of the Society. Two of the Society's distinguished physicians, DR. HERSCHEL PETTIT and DR. WILLETS P. HAINES of Ocean City, were honored by the presentation of Congressional Certificates of Merit and Selective Service Medals signed by President Truman and General Lewis Hershey, director of Selective Service, for serving on draft and selective boards during the war, presented by LT. COL. S. L. SMITH, executive director of New Jersey Selective Service Headquarters. There were 3,482 service men from Cape May County, and up to May 1st 2,311 had been returned to civilian life.

A letter was sent to DR. JULIUS WAY, Cape May Court House, formerly a very active member of our Society, who is now confined to his home with illness.

CUMBERLAND COUNTY

Norman W. Henry, M.D., Reporter

A meeting of the *Cumberland County Medical Society* was held at the Cumberland Hotel, Bridgeton, N. J., April 9, 1946. Twenty-two members attended and DR. G. N. THOMAS, president, presided. Minutes were approved as read.

DR. ALBERT B. KUMP was attending the Council of Industrial Physicians in Chicago. Report of the Welfare Committee for March was read by DR. MURIEL RAMSEY.

The annual election of officers was held, with the following results: *President,* DR. ALBERT KUMP; *Vice-President,* DR. SIDNEY SIEGEL; *Treasurer,* DR. CHARLES SHARP; *Reporter,* DR. NORMAN HENRY; *Executive Committee,* DR. GARRETT MILLER, DR. CHARLES CUNNINGHAM, DR. E. C. LYONS; *Field Marshall,* DR. JAMES KNOWLES; *Delegate,* DR. MARY BACON; *Alternate,* DR. MURIEL RAMSEY.

A resolution was ordered sent to the family of Dr. Kenneth Bauman, whose death is deeply regretted by the Cumberland County Medical Society.

DR. E. A. ROSE of the University of Pennsylvania spoke on thyroid disease and reviewed the status of thiouracil. The speaker analyzed the causes, classification and treatment of the various thyroid disorders. He characterized thiouracil as a valuable and popular drug which sometimes caused untoward reactions. He cautioned practitioners about the

danger of administering this medication without repeated and frequent blood counts and metabolism studies, and warned against prolonged usage. This interesting and instructive talk was followed by a dinner.

A dinner was given by the *Cumberland County Medical Society* at the Cohanzick Country Club, May 1, 1946, in honor of members returning from service.

Dr. Albert B. Kump presided and introduced Dr. Frank Aiken, Dr. Charles Cunningham, Dr. David Green, Dr. Kolbe, Dr. James Knowles, Dr. Lang, Dr. Anthony Pino, Dr. Sol Rosen. Each gave a brief resumé of his army service, relating interesting experiences. Those absent were Dr. Kenneth Corson, Dr. Kratka, Dr. Horace Loder, Dr. Anthony Magolda, Dr. Mary Sherlock and Dr. Rosenthal.

A moment of silence was observed in memory of Dr. Barney Lihn, who lost his life while serving in the European theatre of war.

Music furnished by John Elmer, Lillian Ashley, Bettie Kurts and Mary Carothers of Bridgeton was enjoyed during the dinner.

Those present were: Dr. and Mrs. Garrett Miller, Dr. and Mrs. Charles Sharp, Dr. and Mrs. S. T. Day, Dr. and Mrs. Ware, Dr. and Mrs. Sheppard, Dr. and Mrs. Garrison, Sr., Dr. and Mrs. Garrison, Jr., Dr. and Mrs. Herbert Wilson, Dr. and Mrs. E. C. Lyons, Dr. and Mrs. Franklin Reeves, Dr. and Mrs. Sidney Siegel, Dr. and Mrs. Leonard Scott, Dr. and Mrs. Albert Kump, Dr. Berta Whaland, Dr. and Mrs. H. S. Branin, Dr. Muriel Ramsey, Dr. Burton Walker and son, Dr. and Mrs. Thalheimer, Dr. and Mrs. Charles Gray, Dr. and Mrs. Norman Henry, Dr. Nicholas Marchione and Dr. Mario Pastore.

ESSEX COUNTY

A. A. Ambrose, M.D., Reporter

The Council of the *Essex County Medical Society* met on March 26, 1946, and considered the following matters:

Dr. Crecca reported that a meeting was held with representatives of the Red Cross Chapters of Essex County. The Red Cross is willing to coöperate with the Central Blood Bank Committee if the blood is supplied free of charge. Contributions may be received from welfare agencies or from individuals, but must not be solicited. This matter has been referred to Washington, and a reply is expected in the near future.

Dr. F. C. Weber reported that as a result of a meeting with Commissioner J. A. Brady, Department of Public Affairs, fees to be paid for services rendered under the City of Newark Medical Plan will be $3 per day house call and $5 per night call.

Dr. H. A. Murray asked Council's permission for the establishment of mental hygiene clinics throughout Essex County under auspices of the Essex County Medical Society. Motion was made and passed that the Council favor the institution of these clinics.

Dr. R. A. Schaaf reported that he and Dr. Crecca were invited to attend a meeting by the Newark Evening News to discuss the setting-up of a Newark News Broadcasting System. If the Society is interested, as many programs as requested will be devoted to medical topics. The name of the program will be "Know Your State".

A letter was read from the Physicians Club of Essex County requesting that the Medical Society appoint a committee to assist widows of physicians in the disposal of their husbands' equipment, since it is difficult for them to sell medical equipment at a fair price. This matter was referred to the Public Relations Committee.

Dr. Greifinger reported that complaints have been received regarding the listing of Doctors of Osteopathy in the classified section of the telephone directory under the title Physicians and Surgeons—Doctors of Medicine, and that several of these doctors are using M.D. after their names on prescription blanks and stationery, etc. It was decided that a letter be sent to the Telephone Company, drawing attention to this incorrect listing and asking their coöperation in this matter. Council was also informed that a Doctor of Osteopathy cannot use the title "M.D."

Incorporation of the Central Blood Bank was then discussed, and it was decided that the articles of incorporation should carry the ruling that a majority of the Board of Trustees be physicians.

Dr. Cetrulo outlined plans for graduate medical education in the county and a motion was passed pledging the Society's coöperation with Seton Hall College in offering courses of instruction to our members. The Secretary was directed to reply favorably to the letter received from Dean McNulty of Seton Hall College asking about the joint presentation of graduate courses by the College and by the Medical Society.

HUDSON COUNTY

Harry J. Perlberg, M.D., Reporter

Regular meeting of *Hudson County Medical Society* was held April 2, 1946, at the Masonic Club in Jersey City. It was called to order by the president, Dr. H. H. Tyndall. The Nominating Committee for 1947 was announced as follows: Dr. J. L. Evans, Dr. J. A. Botti, Dr. E. M. Kiely, Dr. T. McG. Brennock and Dr. Harold Sager.

Following applicants were elected to membership: Dr. Vincent P. DePietro of Union City, Dr. Philip B. Keitlen of Jersey City and Dr. James C. Tsucalas of Jersey City.

Dr. Francis F. Haggerty and Dr. Emmanuel F. Ricciardelli were passed by the Board of Censors for reinstatement and Dr. Louis DeRosa was accepted for transfer from the Morris County Society.

Following the Executive Session, Dr. Tyndall turned the meeting over to Dr. Samuel A. Cosgrove, Medical Director of Margaret Hague Maternity Hospital, under whose direction the scientific program was arranged. The speaker, Dr. Herbert Koteen of Cornell Medical School, spoke on the *Management of Syphilis in Pregnancy and Early Infancy.*

An active discussion from the floor followed Dr. Koteen's presentation, Drs. Butler, Emmet Connell,

Jaffe, Katz, McNenney and Louis Pyle participating.

The Society was honored in having as its guest at this meeting the president of The Medical Society of New Jersey, DR. SAMUEL ALEXANDER of Park Ridge, who was given a hearty welcome. Dr. Alexander made a short informal address.

MIDDLESEX COUNTY

Alfred J. Barbano, M.D., Reporter

Regular monthly meeting of the *Middlesex County Medical Society* was held on March 20th, 1946, at the Roosevelt Hospital, Metuchen. The session was called to order by the president, DR. C. HOWARD ROTHFUSS, at 9:30 p.m.

DR. F. M. HOFFMAN, Chairman of the Ethics Committee, recommended that the following named men be reinstated into Society membership: DR. C. W. HOFFMAN, South Amboy; DR. P. RICHLAND, New Brunswick. Names were approved as read, reinstatement granted.

DR. G. W. FITHIAN, Chairman of the Veterans Liaison Committee, addressed the meeting and stated that he now had in his possession a number of applications for authorization of treatment for veterans. These applications could be procured from his office for the Perth Amboy physicians and from DR. MARSHALL SMITH'S office for the New Brunswick members.

DR. NORMAN SCOTT had requested a list of the doctors in the society who are certified specialists in the various branches of medicine. As a result of this request it was duly moved and seconded that the members of the Middlesex County Medical Society be circularized by cards upon which each member was to indicate his specialty, if any, and return to the office secretary. Furthermore, data from these cards were to be the basis for a permanent file of type of practice of each member of the society.

DR. W. C. WILENTZ was elected Alternate Delegate to the State Nominating Committee to replace DR. CALVIN who was ineligible under the State Constitution to vote since he was not a duly elected delegate to the Annual Meeting.

DR. CHARLES W. NAULTY, JR., requested that the following letter be entered upon the minutes of this meeting:

Dr. Malcolm M. Dunham
88 Grove Ave.
Woodbridge, N. J.

My Dear Malcolm:

I have been requested by the President of the Middlesex County Medical Society to write you conveying to you on behalf of the Medical Society the sympathy and condolence of the members on account of the recent loss you have sustained through the death of your father. As a further mark of esteem a copy of this letter will be entered in the minutes of the next meeting.

With kindest regards, I am,

Sincerely yours,

(Signed) CHARLES W. NAULTY, JR.

DR. SAM BERKOW, Chairman of the Entertainment Committee, introduced the speaker of the evening, DR. WILLIAM GOLDRING, Assistant Professor of Medicine, N. Y. U. Medical College, who delivered a very interesting and chronologic discussion on "Medical and Surgical Treatment of Hypertension", appropriately illustrated with lantern slides.

MONMOUTH COUNTY

F. L. Hindle, M.D., Reporter

The *Monmouth County Medical Society* met in the auditorium of the Monmouth Memorial Hospital on February 27, 1945, with DR. GRANVILLE JONES, President, presiding. Despite the inclement weather, the attendance for the second time in 1946 exceeded records beyond the memory of this reporter. Not only were there many faces of new members and returned veterans, but also present were many of the "old regulars" whose attendance had been dilatory in recent years. This unprecedented turnout can be explained only on the basis of the advance billing of our guest speaker for the evening, DR. RICHARD B. CATTELL, Attending Surgeon of The Lahey Clinic, who was introduced to the Society by DR. THOMAS ANDREWS.

The Modern Treatment of Diseases of the Thyroid was Dr. Cattell's subject, and his complete and interesting discussion was enthusiastically received. Dr. Cattell gave us a complete outline of the thyroid states encountered, and amplified his classification with differential diagnostic points in pathology, and in clinical and laboratory findings, and suggested the most favorable therapy for each. The speaker stressed the examination of the thyroid gland by palpation as an informative and helpful procedure in arriving at a correct diagnosis.

Dr. Cattell discussed thyroid surgery, and its complications and sequelae. He emphasized the importance of complete and adequate exposure of the gland, and the routine identification of the recurrent laryngeal nerves and the parathyroid glands. This is routine at the Lahey Clinic in all thyroidectomies.

Lastly, Dr. Cattell reported upon the results of the use of thiouracil at the Lahey Clinic. He was enthusiastic about the benefits of this new drug, and discussed its dosage, optimum duration of its administration, the changes that occur in response to it, its dangers, and its contraindications. Principal use of thiouracil, according to Dr. Cattell, is the preparation of the toxic thyroid patient for surgery, and secondly, as maintenance therapy for patients in whom surgery is contraindicated. Dr. Cattell's talk was illustrated by lantern slides of graphs, pathologic specimens, and clinical material compiled at the Lahey Clinic. After the formal presentation an open discussion followed, and Dr. Cattrell graciously answered many questions.

Dr. Granville Jones called the meeting to order for the transaction of regular business, and advised all members of the pending Senate bill 95 which would permit examination for licensure of graduates of unaccredited medical schools. Dr. Jones urged every member to write to his representative to protest against passage of this bill.

The secretary read a letter from MISS EVELYN T.

Walker thanking the Society for the bon voyage basket sent to her on the eve of her sailing for France. The secretary answered a query from a returned veteran regarding waiving of dues to the Society, by re-stating that veterans discharged in 1945 would not be billed for the years 1945 and 1946.

Motion was made and passed that the following applicants be approved for associate memberships in the County Society: Dr. William D'Elia of Spring Lake, Dr. Edward Dengrove of Marlboro and Dr. Otto D. Sahler of Asbury Park, New Jersey.

Motion was made and passed that the following applicants for transfer to the County Society be approved: Dr. Lester Barnett of Asbury Park, from Middlesex County, and Dr. Sol Shapiro of Leonardo, from Hudson County.

Dr. C. B. Blaisdell, in reporting for the membership committee, stated that since 1941, 76 new physicians had become established in Monmouth County, and that in view of the present doctor-patient ratio additional men should not be encouraged to settle in the county. Dr. Blaisdell also stated that 55 physicians in the county were not members of the County Society.

The President read a letter from Mr. Amory L. Haskell, President of the Monmouth County Jockey Club, stating that it would be necessary to have a physician in attendance at all times when the new race track opens. Dr. Jones suggested that any member interested should submit his name to the Secretary, Dr. L. F. Albright.

Dr. Jones appointed Dr. R. A. MacKenzie Chairman and Dr. W. A. Matthews and Dr. Harry Brindle as members of a committee on arrangements for the annual outing.

Dr. Jones announced that the Nominating Committee would consist of the last five County Presidents: Dr. Holters, Chairman; Dr. Hausman, Dr. MacKenzie, Dr. Kazman and Dr. Featherstone.

The meeting adjourned at 11:30 p.m.

P. S.—Through an oversight in the January report, the name of Dr. Victor Siegel of Red Bank, New Jersey, was omitted from the list of those accepted as associate members of the society.

Monthly meeting of the *Monmouth County Medical Society* was held March 27 at the Fitkin Memorial Hospital in Neptune. Guest speaker, Dr. George Sommer, Jr., of Trenton, was introduced by Dr. Thomas Andrews. Dr. Sommer presented a resumé of his experience in thoracic surgery in the armed forces, and augmented his talk with slides depicting chest wounds before and after operation. In interpretation of x-ray films, Dr. Sommer warned against the too-often-used term of "thickened pleura" when in reality the condition was a clotted hemothorax. Treatment for this condition, Dr. Sommer emphasized, was decortication of the lung, a procedure of great benefit in increasing the rapidity of reëxpansion of the lung and in decreasing the amount and period of drainage. The surgical incision affording best exposure for the removal of foreign bodies from the lung and mediastinum was described and illustrated, and the pictures of many soldiers who had been cured of their thoracic wounds by surgery was indeed a tribute to Dr. Sommer and his associates.

At the conclusion of the scientific program, Dr. Jones called the meeting to order for transaction of regular business. The nominating committee reported the following candidates:

President, Dr. James Pregnall; *President-Elect,* Dr. Louis Albright; *Secretary nad Treasurer,* Dr. Elsworth Baker; *Assistant Secretary and Treasurer,* Dr. Michael Hancock; *House of Delegates for three years,* Drs. Freedman, Woronoff, Pregnall, Feman; *Alternates,* Drs. Hancock, De Vita, Knapp, Edelson.

The secretary reported that there was a bill before Congress to provide funds to enlarge and maintain the Army Medical Library, and that we should lend our support.

The secretary read an appeal from the American Cancer Society to raise $30,000 in Monmouth County, 60 per cent of which would be spent within the county. Members were urged to support this drive.

Dr. Jones reported the Veterans Administration failed to approve and support financially the Screening Clinics which had been established in the county, and that they would necessarily cease to function.

The following applications, approved by the Board of Censors for associate membership in the society, were accepted by unanimous vote: Dr. Martin Rush, Red Bank; Dr. Amerigo George, Long Branch; Dr. James Crilly, Spring Lake, and Dr. Sidney Hanselman, Marlboro.

Dr. Jones stated that his appointed committee for the June outing would be dissolved except for the chairman, Dr. McKenzie, who would select his own committee.

N. J. NEUROPSYCHIATRIC ASSOCIATION

A regular meeting of the *New Jersey Neuropsychiatric Association* was held at the Academy of Medicine in Newark on April 24, 1946. Principal speaker was Dr. Irving H. Pardee of the New York Neurologic Institute, who discussed "The Treatment of Menopausal Syndromes". He was followed by Dr. Julius Sobin, a member of the Society and a Colonel, M.C., A.U.S., who presented an illustrated talk on "Life in the Polynesian Islands". Dr. Lewis Loeser, President of the Society, announced plans for the establishment of intensive advanced courses in both the basic and clinical branches of neurology and psychiatry to begin on September 4, 1946, open to physicians interested in preparing for the American Board examinations or to practitioners who desire to improve their knowledge of neuropsychiatry.

WOMAN'S AUXILIARY

MRS. FREDERICK G. WANDALL, 1946-47 PRESIDENT



Mrs. Frederick G. Wandall, nee Thelma Elizabeth Summerson, was born near Lynchburg, Virginia.

Her formal education included Sullins College, Bristol, Virginia, and West Virginia University, Morgantown, where she was graduated in "Public School Music" in 1926. In May of that year she married Dr. Wandall, then a medical student at Pennsylvania University, and went to live in Philadelphia until his graduation in 1928. During that time Mrs. Wandall taught music in the public schools.

After Dr. Wandall finished his internship at Cooper Hospital, Camden, the couple moved to their present home in Clayton, Gloucester County. Dr. and Mrs. Wandall have two sons, Frederick S., age sixteen, and William M., age thirteen.

Mrs. Wandall is an inactive member of the Order of Eastern Star; and an active member of the Episcopal Church, the Woman's Club of Pitman, and the Philadelphia Alumnae Chapter of Delta Gamma fraternity. She organized the cancer control group in Clayton, and has served in the field army of that town four years. Mrs. Wandall has held various offices in the Auxiliary to the Gloucester County Medical Society, and was president in 1938 and 1939. In the Auxiliary to The Medical Society of New Jersey she was director and Hygeia chairman for two years.

INAUGURAL ADDRESS

By Mrs. Frederick G. Wandall, President
The Woman's Auxiliary to The Medical Society of New Jersey

May 22, 1946

It is with heartfelt gratitude that I appear before you as your new president. It is my hope and prayer that I will be worthy of the trust and honor which you have bestowed upon me.

Acceptance of the task of steering the course of the Auxiliary to The Medical Society of New Jersey through the year ahead is more than an honor. It is a sacred privilege; one which would be beyond the gifts of a single individual, were it not for the faithful coöperation the president of this organization has always had. I am keenly aware of the confidence you have shown me, and shall try to be worthy of it, although it is with a sense of deep responsibility that I assume the duties of so able a predecessor. We have in our Auxiliary common aims and ideals, transcending this year anything we have known in the past. A world catastrophe has not changed our course; it has only intensified the need for our closer cohesion. And as homemakers and guardians of the happiness and tranquility of the most needed group in the world today, ours is preëeminently an important rôle.

Since our nation has been involved in a death struggle against brutality and atheism, and since our own loved ones have been a part of this struggle, we have no alternative but to serve to the very limit of our strength and capacity for world peace.

As your president I shall have but one design—that we shall be so united, so strong, so forceful, no smallest opportunity for service to our Medical Society shall pass us by. The first step to that end has been to preserve in every way possible the program already so well begun. Our task is great, there is work for all. Every member will find that peace has opened new fields of service where she may be at the head of many things. If we but see our work in its true importance, every member will be a committee of one among lay health groups. As individuals we must see to it that greater attention is focussed on a greater number of health sessions in club programs everywhere.

It is vital that every county in the state be organized. I do not know that this can be accomplished, but we must bend our every effort in that direction. No county is so small that it may feel that what it does or does not do makes no difference. I have every confidence that before another year rolls around there will be many new members added to our list. This may not be a speedily accomplished task, but a gradual growth will produce quality. And quality of organization far exceeds growth based on numerical index alone. Much of this quality is due to the wise leadership and judgment of our past officers. Our imperative need today is an undistorted sense of values, constructive in thought, logical in reasoning, and sound in judgment; combined with common sense and good teamwork. Service to physicians in individual counties is your keynote, as organized Auxiliary units.

Tomorrow is an unknown and precarious adventure. Shall we as an Auxiliary give an account of ourselves in which we may justifiably take pride and for which we may reasonably claim recognition? As your President I shall serve you to the best of my ability, and strength, towards such a goal.

FINAL ADDRESS OF PRESIDENT

MRS. WILLIAM E. DODD, President 1945-46

May 22, 1946

It seems like yesterday when I had to forego the pleasure of the 1945 luncheon and installation as your president because of illness.

V-E Day had just passed and our hopes and prayers were for a speedy victory in the Pacific. That seemed paramount—but here at home, as Auxiliary members, we recognized the task remaining for us.

In my acceptance speech I defined the duties of the president of the Woman's Auxiliary to The Medical Society of New Jersey. Briefly they were to preside at meetings and to promote the objects of the Auxiliary. In reality, it includes a great deal more. During the year I have worked steadily to promote good fellowship, to conserve our resources, to increase our membership and to coöperate with the National Auxiliary.

I am ever mindful of the confidence, sympathy and support each one of you has offered me. Alone a president can accomplish very little. Together we can build an organization whose influence in national affairs will have a great effect.

I appreciate the good work of all the organized Auxiliaries and am very sorry that no new reorganization has been accomplished. No doubt, in the near future, when normal living is ours again we will have the opportunity of welcoming every doctor's wife in the state into the Auxiliary.

Today America faces a challenge of world leadership. It is necessary that we as doctors' wives wake up to the fact that we must be true partners. That it is our duty to help build a healthier, stronger America. This morning we heard Dr. Harrold Murray plead for interest in child welfare, Mrs. Lippincott can tell us of the toll of cancer and Dr. Kalb can demonstrate the necessity of proper nutrition. We hear of the threat to organized medicine and unless we do concern ourselves with these matters we will not be world leaders and the peace we thought we had won will not be ours.

I am very happy to see so many of you here today and I wish to express my appreciation to each one of you for the honor I have received as your president and for the coöperation which has been mine and which I trust will be accorded our new president, Mrs. Frederick G. Wandall.

Together let us strengthen our Auxiliary for *"Today is but the stepping stone to tomorrow."*

AUXILIARY CONVENTION REPORT

The 19th Annual Convention of the Woman's Auxiliary to The Medical Society of New Jersey took place in Atlantic City May 21, 22 and 23, 1946.

On May 21, a preconvention Board meeting was held in the Hotel Claridge with Mrs. William E. Dodd of Beach Haven, President, presiding. On the same evening, the annual dinner of the Fellowettes (an organization of the past presidents of the Auxiliary) was held in the Traymore Hotel, at which time the installation of Mrs. Dodd, out-going Auxiliary President, as a Fellowette took place. Mrs. David B. Allman, junior past-president of the Auxiliary, who was in charge of the arrangements of the dinner, was hostess to the entire group.

On May 22, Mrs. William E. Dodd, retiring President of the Woman's Auxiliary, entertained her entire Board at breakfast.

At 9:30 a. m. the 19th Annual Meeting of the Auxiliary was held in the Hotel Traymore, Mrs. William E. Dodd, President, presiding. Invocation was given by the Rev. J. Stanley Wagg, St. Paul's Methodist Church, Atlantic City. Mrs. Robert A. Bradley, President of the Woman's Auxiliary to the Atlantic County Medical Society, greeted the Convention, welcoming it to Atlantic City, and wishing it a pleasant visit. Mrs. Frederick G. Wandall, President-Elect of the Auxiliary, in response to this pleasant welcome, said that Atlantic County had long had the blue ribbon as a hostess county. Mrs. George A. Rogers, Fellowette of 1937, conducted the memorial service for departed members (see page 260). She was assisted by the Misses Jane Rieck and Barbara Johnson, Junior Aides.

Dr. William E. Dodd of Beach Haven, chairman of the Advisory Committee to the Woman's Auxiliary for The Medical Society of New Jersey, came to thank the Auxiliary on behalf of The Medical Society. He said that the loyalty of the organization had been an inspiration and a source of comfort to the men who had been doing the work of organized medicine; that the Auxiliary had within it many potentialities for service to the medical profession.

Dr. Dodd then introduced Dr. Frank G. Scammell of Trenton, incoming President of The Medical Society of New Jersey, who said he felt the Auxiliary was an indispensable part of their organization, and that he would count on the Auxiliary for help. Mrs. Dodd thanked Dr. Dodd in the name of the Auxiliary for his help throughout the year, and Dr. Scammell for his interest in the work of the Auxiliary.

Following this, Dr. Harrold A. Murray, state chairman of the American Academy of Pediatrics and chairman of the Advisory Committee on Child Health, appeared before the meeting to ask the members of the Auxiliary to help in a nationwide survey of child care in each state. The American Academy of Pediatrics wishes this survey of existing facilities of child care, so that it will have on hand definite statistics to permit intelligent analysis of current legislation. All wives of physicians are asked to see that their husbands fill out and return the form soon to be sent by Dr. Murray's committee.

The Convention, already in festive mood by the graciousness and charm, to say nothing of the picturesqueness, of its presiding officer, took on an added significance upon the arrival of two very distinguished visitors who were in Atlantic City for the Daughters of the American Revolution Convention: Mrs. V. Eugene Holcombe of Charleston, West Virginia, who was the President of the Auxiliary to the American Medical Association 1940-1941, and Mrs. James N. Brawner of Atlanta, Georgia, who organized the Auxiliary to The Medical Society of Georgia 22 years ago, and who in recognition of that service has been made Honorary President of that Auxiliary for life. Mrs. Holcombe brought greetings from the National Auxiliary and complimented the New Jersey Auxiliary on its outstanding work in health education among various women's groups. Dr. and Mrs. Holcombe and their daughter, Mrs. Buckle of Birmingham, were among the notable and distinguished guests of the Auxiliary in the evening at the banquet honoring Dr. Samuel Alexander.

Final speaker of the morning session, Mrs. A. Haines Lippincott, State Commander of the American Cancer Society and beloved first president of the Woman's Auxiliary to The Medical Society of New Jersey, pleaded for the support of Auxiliary members in the cancer education program, and said that speakers, programs and exhibits were available for lay groups.

Following the luncheon given by the members of the Auxiliary in honor of Mrs. William E. Dodd for her outstanding contribution to the Auxiliary (see page 260), the meeting reconvened and the election and the installation of officers took place. Mrs. Ralph J. Faulkingham of New Brunswick offered resolutions which were spread upon the minutes to thank Mrs. James H. Mason of Atlantic City and her committee for their untiring efforts on be-

half of the Auxiliary, to thank Atlantic County Auxiliary for its hospitality, and the managers of both the Traymore and the Claridge for their many courtesies.

AUXILIARY TO THE MEDICAL SOCIETY OF NEW JERSEY

Officers 1946-1947

President — Mrs. Frederick G. Wandall of Clayton, New Jersey
President-Elect — Mrs. Lodovico Mancusi-Ungaro, Newark
First Vice-President—Mrs. Andrew C. Ruoff, Union City
Second Vice-President—Mrs. C. Chester Chianese, Trenton
Secretary—Mrs. Banks S. Baker, Camden
Treasurer — Mrs. Thomas P. McConaghy, Camden
Directors 1946-1949—
Mrs. Chester I. Ulmer, Gibbstown
Mrs. Abraham Jaffin, Jersey City
Director 1946-1948 (to fill unexpired term)—
Mrs. Joseph E. Mott, Paterson
Director 1946-1947 (to fill unexpired term)—
Mrs. Samuel H. Jesserun, Newark

NINETEENTH BIRTHDAY PARTY

The Nineteenth Birthday Party was in honor of Mrs. William E. Dodd of Beach Haven. All the past presidents of the Auxiliary were seated at a head table beautifully decorated with flowers. Dr. and Mrs. Alexander, Dr. Ivor Griffith, the guest speaker; Mrs. William E. Dodd, the guest of honor, and Mrs. Frederick G. Wandall, the incoming president of the Auxiliary, also sat at the head table. Mrs. Asher Yaguda of Newark was the toastmistress and she introduced each member of the guest table prettily and effectively. Of Mrs. Dodd she said: "She has left no stone unturned, she has dedicated herself with all her heart to Auxiliary work . . ."

Dr. Alexander, President of The Medical Society of New Jersey, brought the Auxiliary greetings of the State Medical Society. He said that he was convinced that the Auxiliary played an important part in the work of the Medical Society, and that the average wife of a doctor knows much about the problems of organized medicine, and they are important in combating political propaganda inimical to organized medicine through their participation in community interests.

Dr. Ivor Griffith, Ph.M., Sc.D., F.R.S.A., President, Philadelphia College of Pharmacy and Science, was the speaker of the afternoon. This, said Dr. Griffith, is the cruelest and the saddest day of the world in potentialities. The release of atomic power has brought into man's domain something greater than man has ever seen. There is already on hand enough if put into one missile to crack the world in half. Atomic energy promises to revolutionize industry and medicine, and offers a possible approach for the treatment of that scourge of all scourges — cancer. The knowledge of this power is still only at the beginning: as a model T is to a Diesel engine, so is the atomic power of today to the inventions of tomorrow. Dr. Griffith said that Dr. Fishbein had done well by American Medicine; that he had done a prodigous work for Organized Medicine with his God-given and Fishbein-developed talents.

Mr. Raymond Morley's talk of the four freedoms leaves out the most important one: You can have freedom of expression, freedom of worship, freedom of fear, and freedom of want, and still be a bird in a cage. Free enterprise made America, and it is the spirit that should make a fine America for our children tomorrow.

Following Dr. Griffith's talk, Mrs. A. Haines Lippincott, the first Fellowette of the Auxiliary, presented the Past-President's Pin to Mrs. Dodd.

THE WOMAN'S AUXILIARY

IN MEMORIAM

ATLANTIC—*Mrs. W. Blair Stewart*
BERGEN—*Mrs. Henry Briody*
ESSEX—*Mrs. Max Danzis*
Mrs. Otto Matheke, Sr.
Mrs. A. Charles Zehnder
Mrs. John F. Judge
HUDSON—*Mrs. William Freile*
MERCER—*Mrs. Howard Ivins*
UNION—*Mrs. Frederick Kinch,* Fellowette 1936

THE FELLOWETTES' DINNER 1946

The Fourth Annual Dinner of the Fellowettes was held at the Traymore on May 21, 1946. Mrs. A. Haines Lippincott presided. Fourteen Fellowettes were present. Election of officers took place. Mrs. Lippincott was elected president for life, Mrs. Epler was re-elected Secretary-Treasurer.

Mrs. William E. Dodd was inducted into the society as a Fellowette. Mrs. Dodd pledged her continued support to the Auxiliary and to the Fellowettes.

Mrs. F. G. Wandall, the new president of the State Auxiliary, was presented the State President's pin; Mrs. Wandall's acceptance speech, "A pin in the shape of a star was pinned on my dress; such fine ideals as are embodied in the ceremony of pinning on the emblems should make one proud and I desire to have those concerned feel they did not make a mistake when they entrusted their pin to be placed over the heart of their leader."

The Fellowettes again pledged their willingness to assist the State Auxiliary on any project whenever aid was needed.

Brought to the attention of the group for discussion was the feasibility of having conferences for county presidents for the purpose of bringing the county Constitution and By-Laws in line with the state Constitution and By-Laws. It was also suggested that the duties of the county presidents and chairmen should be clarified to speed up the programs put forth by the state and national Auxiliaries, and to help the counties follow these programs.

A sympathy resolution was unanimously adopted on the passing of Annabelle Kinch to be spread on the minutes of The Fellowettes of the Auxiliary to The Medical Society of New Jersey.

The Fellowettes were the guests of Mrs. David B. Allman and a rising vote of thanks was given to Mrs. Allman for a delightful dinner.

Betty Epler, Secretary.

COUNTY AUXILIARIES

Camden County

Mrs. Thomas H. McGlade, Chairman of Publicity

The public relations meeting of the *Woman's Auxiliary to the Camden County Medical Society* was held at the Camden Woman's Club Tuesday, March 19th, 1946, at 2 o'clock.

Mrs. Reuben L. Sharp, President, welcomed the members and guests and introduced our State President, Mrs. William E. Dodd, of Beach Haven.

Mrs. A. Haines Lippincott gave a brief talk on cancer. She made an appeal for old linen, to be used for the many surgical dressings, so urgently needed in this work throughout the State.

Dr. Samuel B. Hadden, neuropsychiatrist, associated with the Presbyterian Hospital, Philadelphia, Pa., was introduced as guest speaker by Mrs. Edmund C. Hessert, public relations chairman. Dr. Hadden spoke on postwar neuroses. Following his address there was an interesting discussion.

The meeting concluded with a delightful tea served by Mrs. George B. German and her hostesses of the afternoon.

Mrs. Reuben L. Sharp, President of the *Woman's Auxiliary to the Camden County Medical Society*, entertained the members of the Executive Board at a delightful luncheon at her home on April 16.

The annual reports from the committee chairmen were read following the luncheon.

The money realized from the proceeds of the Annual Card Party and Fashion Show was allocated to various charity organizations.

Mrs. George B. German, Hospitality Chairman, announced that the annual luncheon meeting will be held at Medford Lakes Lodge on May 7. Mrs. A. Lincoln Sherk, Program Chairman, has been fortunate in obtaining Mr. Francis Bosworth, Director of Friends Neighborhood Guild of Philadelphia, Pa., as the speaker at this meeting. His topic will be "Intimate Glimpses Backstage".

Essex County

Mrs. Rocco Marra, Publicity Chairman

The *Woman's Auxiliary to the Essex County Medical Society* held their meeting on April 22. The Board Meeting was followed by the regular meeting at 12:00 and a luncheon at 1:00. Guest speakers were Dr. Joseph I. Echikson, chairman of the Cancer Committee of the Essex County Medical Society, and Harry A. Murphy, manager of the organizational division of the American Cancer Society.

Dr. Echikson stressed the importance of early diagnosis and treatment of cancer. Cancer research, he said, has gone so far it is probable that within a short time the cause of cancer will be discovered, bringing about a cure of the disease.

Mr. Murphy spoke of the work of the Cancer Society and its current campaign for funds, greatly needed. He said he knew of the many lives destroyed by cancer and of the fact many might be saved, and will be saved through donations used for research.

Mrs. Daniel E. Kavanaugh introduced the speakers. She also presented Mrs. Ernest C. Reock of Belleville, president of the Contemporary of New-

ark. Preceding the general meeting, the Auxiliary entertained Contemporary members at a dessert luncheon.

The Woman's Auxiliary gave a tea in honor of mothers of doctors, who are members of the society, on May 8 at 2:00. At the meeting preceding the tea. Mrs. H. Roy Van Ness of Newark spoke on the history and purpose of the Auxiliary. Miss Dorothy C. Goodell of Maplewood, harpist, entertained with many beautiful selections.

Middlesex County

Mrs. Norman Rosenberg, Chairman of Publicity

Mrs. Irving Cronk was hostess at a covered dish supper Tuesday, April 30, 1946, at 7 p.m. at her home, 57 Livingston Avenue, New Brunswick, for the members of the *Woman's Auxiliary to the Middlesex County Medical Society.*

During the business meeting Mrs. C. F. Merrill announced that many surgical instruments had been collected from the county physicians to be sent to The Netherlands.

Mrs. William Stein reported that nominations and elections will take place at the annual luncheon May 28, and Mrs. Ralph J. Faulkingham and Mrs. Nathan Karshmer reported that $100 was raised on individual card parties.

Mrs. L. A. M. Feher and Mrs. Faulkingham were appointed delegates to the annual convention to be held in Atlantic City with Mrs. M. S. Brody and Mrs Robert Walker as alternates.

Ocean County

Mrs. Emanuel Sickel, Chairman of Publicity

The *Woman's Auxiliary to the Ocean County Medical Society* conducted its annual public relations meeting and tea Friday, April 5, at the Y. W. C. A. of Lakewood, at which time awards were presented for essays on "Medicine's Contribution to Victory".

Mrs. Carl Menge, president, awarded $5 each to David Harrison, Lakewood High School junior; James Glennon, Toms River High School senior, and Lorraine Evanson, Barnegat High School senior. Ruth Schindler, Lakewood High School senior, received honorable mention.

Mrs. Raymond Taylor, public relations chairman, presented the speakers. Dr. Otto Holters of Asbury Park spoke on "Public Enemy No. 1—Cancer". Mrs. A. Haines Lippincott, state commander of the American Cancer Society, continued the discussion of cancer. Dr. William L. Rumsey, chairman of the state's Crippled Children Commission, spoke on "Rheumatic Fever", and A. Paul King, Ocean County Freeholder, explained the part played by the Ocean County Health Department in coöperating with health movements.

Tea was served with Mrs. William E. Dodd of Beach Haven, president of the Woman's Auxiliary to The Medical Society of New Jersey, and Mrs. Leon Taylor, chairman of ways and means, as hostesses.

Also attending were Mrs. David B. Allman, junior past president of the Woman's Auxiliary to The Medical Society of New Jersey; Mrs. Robert Bradley, president of the Atlantic County Auxiliary, and Mrs. James Mason, a past president of the Atlantic County Auxiliary.

Passaic County

Mrs. Irving Silverman, Chairman of Publicity

The *Woman's Auxiliary to the Passaic County Medical Society* held its March meeting at the home of Mrs. E. J. Hatem in Clifton on March 18, 1946.

In the absence of the president, Mrs. Joseph E. Mott, the first vice-president, Mrs. Albert G. Markel conducted the meeting.

Excellent committee reports were given by the chairmen of the various committees.

Three new members were introduced: Mrs. Frank Barlow, Mrs. R. C. Yeaw and Mrs. James Morrill.

Plans were made for the public meeting to be held at the Paterson Woman's Club on April 8 at which time a well known authority on cancer will speak.

Miss Gladys Wilensky, State Board of Children's Guardians, gave an interesting and informative talk on "Foster Homes for Children."

Mrs. Max Weinman, state chairman of legislation, spoke at length on state legislation and its relation to the medical society.

Warren County

Mrs. Herman Baldauf, Chairman of Publicity

Mrs. Floyd A. Shimer, president, was in charge of the meeting of the *Woman's Auxiliary to the Warren County Medical Society* held April 15, when Mrs. William E. Dodd of Beach Haven, president of the Woman's Auxiliary to The Medical Society of New Jersey, was the guest speaker.

Plans were discussed for continuing the drive to obtain used medical equipment to send to the physicians in The Netherlands. Plans were also made to attend the State Auxiliary convention to be held in Atlantic City in May. Reports were presented on the recent card party.

The nominating committee reported the following candidates for the ensuing year: Mrs. G. Homer Bloom, president; Mrs. Walter Boquist, first vice-president; Mrs. Ralph Buchanan, second vice-president; Mrs. Charles Potter, secretary; Mrs. Paul F. Drake, treasurer.

Following the business meeting the members of the Auxiliary joined with the members of the Warren County Medical Society for luncheon.

Attending were Mrs. Guernsey West, Mrs. Hubert Adler, Mrs. Emory Krausz, Mrs. Russell B. Stone, Mrs. Floyd Shimer, Mrs. G. H. Bloom, Phillipsburg; Mrs. Herman Baldauf, Mrs. Clyde Marlett, Belvidere; Mrs. Charles Potter of Washington; Mrs. Joseph Humbert and Mrs. Elizabeth Curtis of Stewartsville.

Tuberculosis Abstracts

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XIX June, 1946 No. 6

THE PHYSICIAN in general practice is frequently asked to determine which of the lesions uncovered by X-ray are active and need treatment and which are non-active and need only careful watching. To the private physician also comes the patient newly home from the sanatorium asking for guidance during the critical period following his hospital discharge. These difficult and delicate decisions call for the highest diagnostic and therapeutic skill. Unless they are made promptly and well, the control of tuberculosis will never become a reality.

DIAGNOSIS AND POSTSANATORIUM CARE IN PULMONARY TUBERCULOSIS

Familiarity with tuberculosis if it has not bred contempt has led at least occasionally to oversight on the part of physicians who have been lulled into complacency by the declining death rate. An occasional review of a disease, even so familiar a one as tuberculosis, helps to focus attention upon it. Two cases illustrate this point.

In the first case, a woman came to the sanatorium after having had a cough for an extended period of time. She had consulted her physician because of this cough and had even suggested tuberculosis. This possibility was ignored. After some months she consulted another physician. A diagnosis of tuberculosis was made at once. By this time her tuberculosis was very far advanced.

In the other case, a patient had consulted a reputable doctor for a like complaint and had requested a sputum examination. This doctor, likewise, was reluctant to consider such a possibility. After several months the woman consulted another physician and a sputum sample was obtained. Tubercle bacilli were present and the patient was admitted to the sanatorium.

It is desirable to refer patients back to their original family physicians after they are ready to leave the sanatorium, but it becomes difficult, if not impossible, in such cases.

Diagnosis. Diagnosis of tuberculosis may be reviewed very briefly before passing on to post-sanatorium treatment. In the diagnosis of tuberculosis the Mantoux test, preferably using P.P.D., is very reliable. A negative test means that the patient has not had tuberculosis or, as infrequently happens, has healed a tuberculosis by calcification so that all tubercle bacilli are killed. In a very far advanced, very active disease, the test will be negative occasionally. A positive test means that at some time the patient has had an active tuberculosis. It will not indicate whether or not the disease is now active nor in what part of the body it is located.

A clinical history is essential in a diagnosis of pulmonary tuberculosis. Only one or two symptoms may be present, however, and a patient can have an active disease that is practically asymptomatic. Our old classic symptoms of pulmonary tuberculosis consist of afternoon fever, loss of weight, loss of strength, night sweats, cough, hemoptysis and dyspnea, usually with an increased pulse rate. Any of these symptoms, particularly a persistent cough, demands a very careful examination for tuberculosis including an X-ray of the chest.

Results of physical examination will vary greatly, depending on the location and extent of the lesion. Unfortunately, only positive findings can be relied upon.

For X-ray examination the 14″x17″ stereo plate is the one to be desired. The 14″x17″ single plate is fairly reliable but not as accurate as the 14″x17″ stereo. The miniature film is used mainly for mass survey work and is not reliable as the sole diagnosis in a given case of tuberculosis.

In laboratory examination of sputum, the direct smear is unreliable, unless the organisms are found. In case the organisms are not found, examination of the concentrated sputum (or fasting gastric contents) should be made. The culture is more

reliable than the concentrate examination while guinea pig inoculation is of still more value. A single negative sputum is not reliable. A patient with a far advanced tuberculosis, even with cavity formation, may have a consistently negative sputum. The blood count is not a reliable diagnostic aid, although there is usually an increased white count with some disturbance in the differential. The monocyte count is increased. It is impossible to use this, however, as a differential diagnostic base. Sedimentation rate is usually increased and may run as high as 150.

On differential diagnosis atypical pneumonias may be rather difficult to rule out, particularly in the case of an active tuberculosis with a negative sputum. However, an atypical pneumonia is more frequently found in the lower portion of the lung field. Bronchiectasis is usually located in the lower portion of the lung field near the mediastinum and can be confirmed by lipiodol visualization.

The metastatic malignant tumors are usually rather easy to recognize. The occasional gelatinous tuberculous infiltrate may resemble a metastatic nodule. The original malignancy frequently may be detected in some other portion of the body. A bronchogenic type of malignancy usually differs quite markedly on the X-ray from a tuberculous infiltration. Non-malignant tumors are usually easily differentiated from a tuberculosis. Boeck's Sarcoid somewhat resembles tuberculosis and is usually in the mid-portion of the lung field. Sputum is negative and the Mantoux is likewise negative. A bronchitis usually presents no radiographic findings except for slightly increased markings and is usually in the lower portion of the lung field. Cardiac involvement shows a marked increase in the transverse diameter of the heart. The fungus infections are usually discovered easily on sputum examination. The various types of pneumoconiosis are frequently seen in mining communities.

Postsanatorium Treatment. All patients should be kept at the sanatorium until they have had at least two hours' walking exercise daily for a period of two months. Their sputum must be consistently negative and the X-ray must show regression of the lesions. The patient must be afebrile. Treatment at home will depend on the treatment given at the sanatorium. Suggested treatment at home for the patient who has received no collapse therapy should include two hours of rest in the morning and two hours in the afternoon. The rest periods should be observed strictly at the same hours each day. It is important to have the patient retire at the same early hour each night. If the patient stays up until midnight some nights, it is impossible to regain what has been lost, even were he to stay in bed the entire next day.

With only two hours' walking exercise, no work is to be attempted. It is usually possible to increase the walking exercise about ten minutes a week. Sputum and X-ray examinations should be secured at three-month intervals. When a patient with pneumothorax is discharged from the sanatorium the above treatment will be supplemented by pneumothorax refills at intervals. The length of time between refills and the amount of air at each refill will vary depending on the rate at which the patient absorbs the air and on his activity. This can be determined only by close observation of the patient and fluoroscopic examination or X-rays at frequent intervals. A patient with a phrenic, thoracoplasty, or a paraffin pack requires the same postsanatorium treatment as the patient without any collapse therapy. A patient with an extrapleural pneumothorax requires the same care as the patient with an intrapleural pneumothorax.

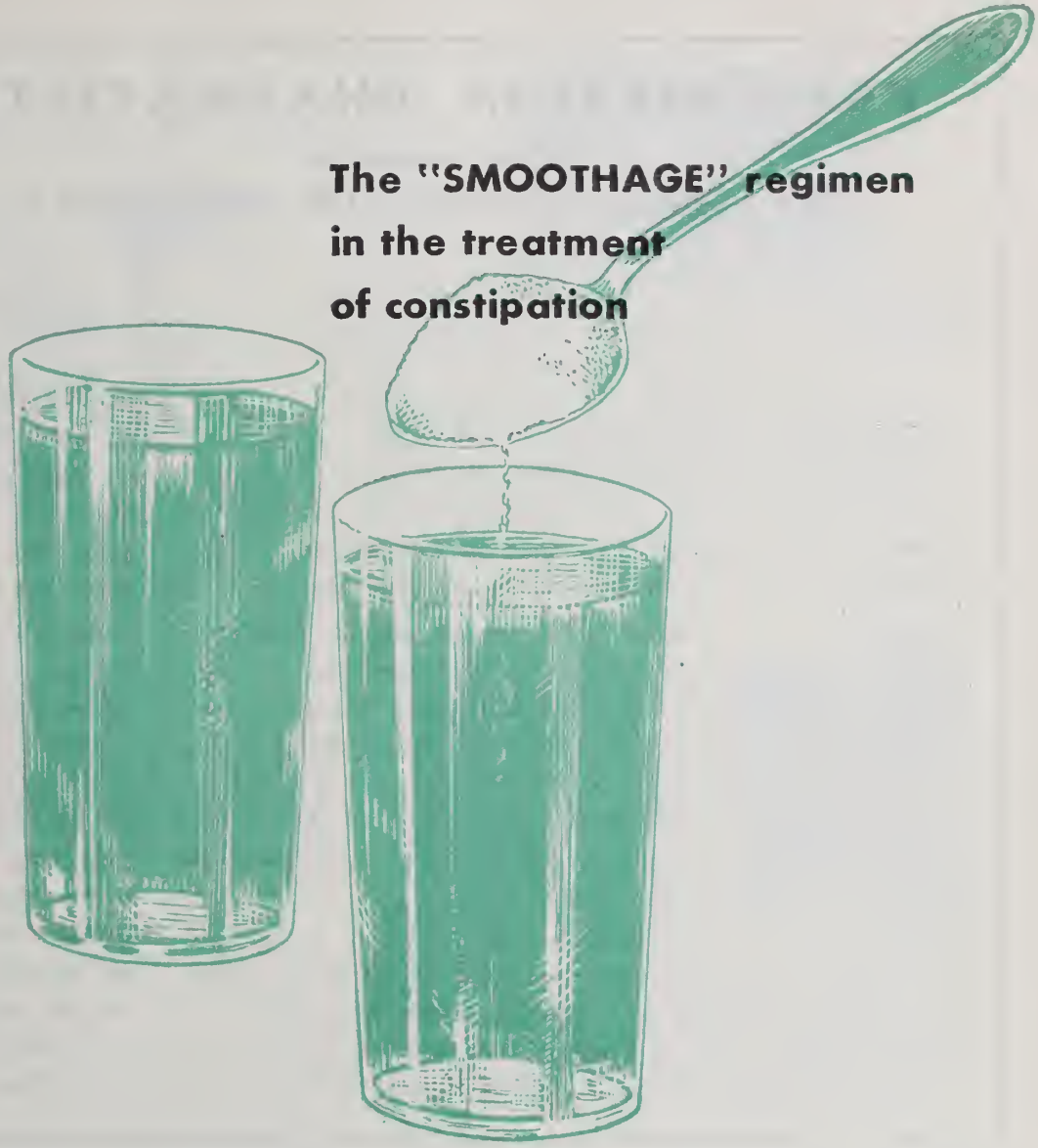
Diagnosis and Postsanatorium Care in Pulmonary Tuberculosis, W. L. Meyer, M.D., The Journal-Lancet, December, 1945.

SUPPLIED BY

New Jersey Tuberculosis League

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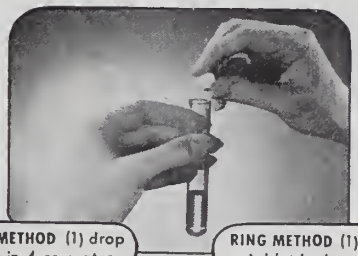


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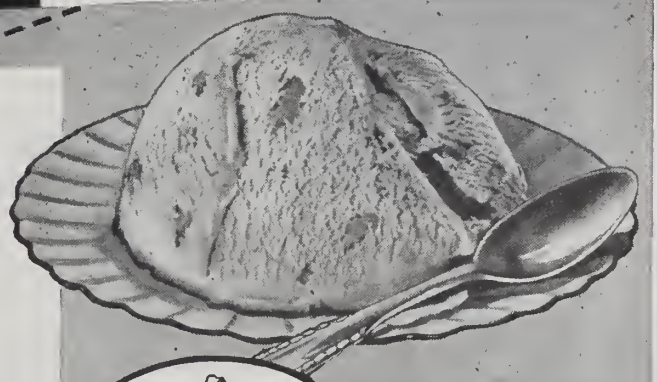
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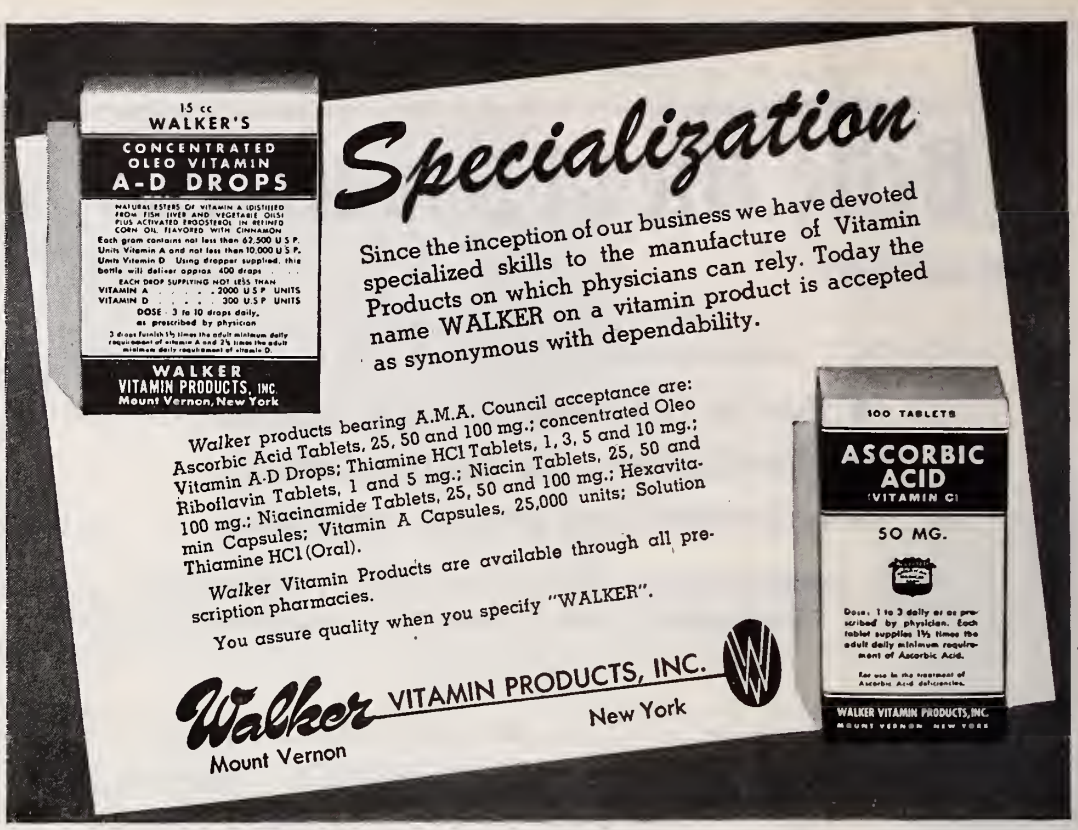
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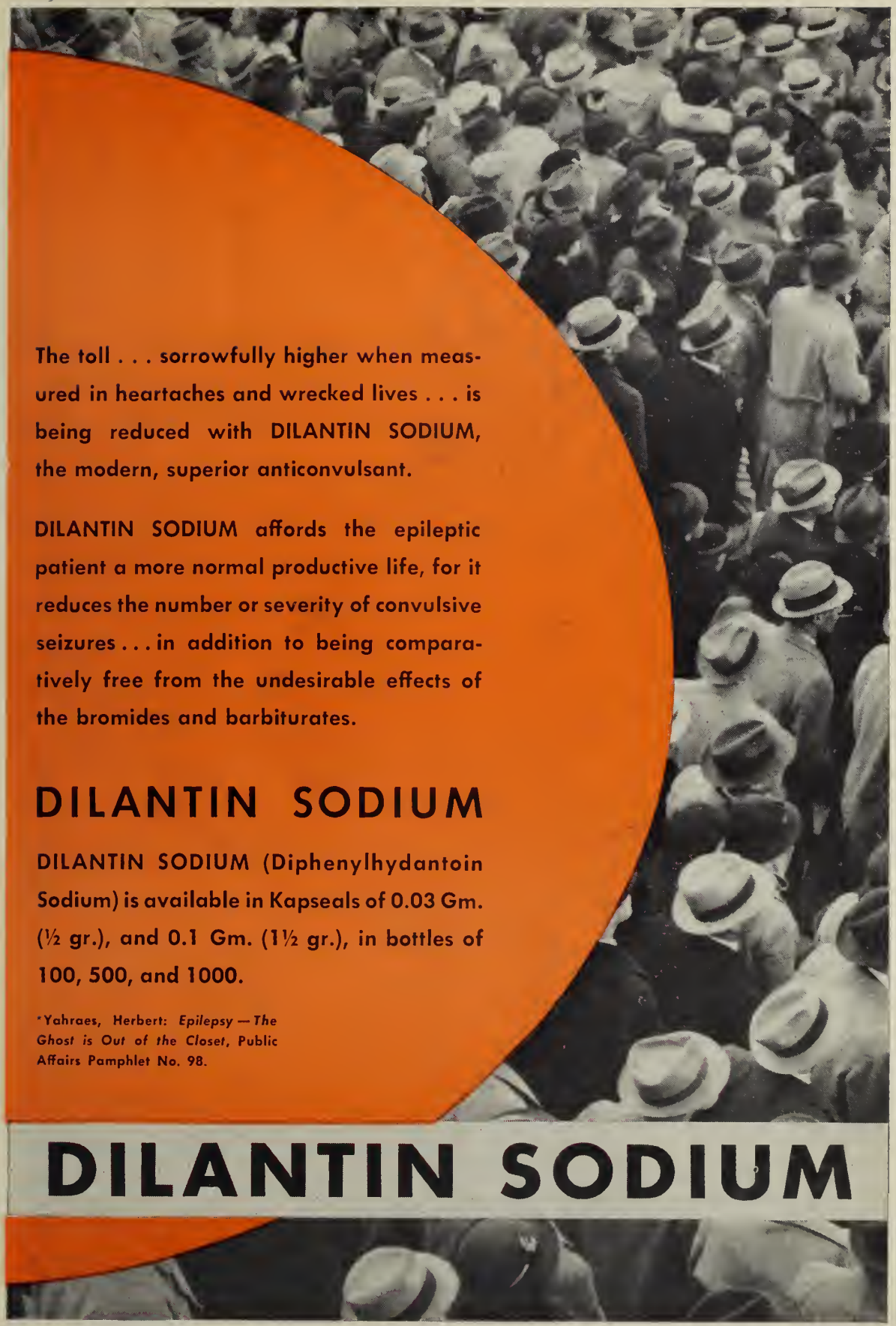
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Entered as second-class matter, September 5, 1906, at the post office at Orange, New Jersey, under Act of March 3, 1879.

VOL. 43, NO. 7 JULY, 1946 Subscriptions, $3.00 per Year
Single Copies, 30 Cents

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Place of Publication, Printing and Mailing:
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Editorial and Executive Offices of the Society:
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Third District (Mercer, Middlesex, Somerset and Hunterdon Counties).....BARCLAY S. FUHRMANN, Flemington (1949)
Fourth District (Camden, Burlington, Ocean and Monmouth Counties).....S. EMLEN STOKES, Moorestown (1948)
Fifth District (Cape May, Cumberland, Atlantic, Gloucester and Salem Counties).....CHESTER I. ULMER, Gibbstown (1947)
President (Ex-Officio).....FRANK G. SCAMMELL, Trenton

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Delegates

LUCIUS F. DONOHOE (1947).....Bayonne
WILLIAM F. COSTELLO (1947).....Dover
WELLS P. EAGLETON (1948).....Newark
HILTON S. READ (1948).....Ventnor
THOMAS K. LEWIS (1948).....Camden

Alternates

RALPH K. HOLLINSHED (1947).....Westville
SPENCER T. SNEDECOR (1947).....Hackensack
ELMER P. WEIGEL (1948).....Plainfield
LANCELOT ELY (1948).....Somerville
CLARENCE W. WAY (1948).....Sea Isle City

DELEGATES TO OTHER STATES

Delegates

Connecticut—ALFRED STAHL (1947).....Newark
New York—JAMES F. NORTON (1947).....Jersey City

Alternates

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New York—D. WARD SCANLAN (1947).....Atlantic City

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Eye, Ear, Nose and Throat

CHARLES W. BUVINGER, *Chairman*.....East Orange
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N. J. State Department of Institutions and Agencies

SANFORD BATES, LL.D., *Commissioner*
State House Office Building, Trenton 8, N. J.
Tel. 2-2131, Ext. 737

N. J. State Department of Public Instruction

WILSON G. GUTHRIE, M.D., *Director of Health, Safety and Physical Education*
Room 1302, 28 W. State St., Trenton 8, N. J.
Tel. 2-2131, Ext. 230

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Room 732, 143 E. State St., Trenton 8, N. J.
Tel. 2-2131, Ext. 8174

N. J. Rehabilitation Commission
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163 W. Hanover St., Trenton 8, N. J.
Tel. 2-2131, Ext. 308

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Tel. 2-2131, Ext. 272

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State House Office Building, Trenton 8, N. J.
Tel. 2-2131, Ext. 208

N. J. State Department of Health
J. LYNN MAHAFFEY, M.D., *Director of Health*
Room 232, State House, Trenton 8, N. J.
Tel. 2-2131, Ext. 541

N. J. State Nurses Association
MISS WILKIE HUGHES, R.N., *General Secretary*
Room 1112, 17 Academy St., Newark 2, N. J.
Tel. Market 3-6361

N. J. Hospital Association
GEORGE O'HANLON, M.D., *Executive Secretary*
Jersey City Medical Center, Jersey City 4, N. J.
Tel. Bergen 3-7000

N. J. Pharmaceutical Association
JOHN J. DEBUS, *Executive Secretary*
Room 318, 28 W. State St., Trenton 8, N. J.
Tel. 5596

N. J. State Dental Society
FRANK K. HEAZELTON, D.D.S., *Executive Secretary*
223 E. Hanover St., Trenton 8, N. J.
Tel. 5084

N. J. Health Officers' Association
WILLIAM C. BLAKE, *Secretary*
Thomson Hall, Princeton, N. J.
Tel. 1005

N. J. Health and Sanitary Association
L. VAN D. CHANDLER, *Executive Secretary*
346 State St., Hackensack, N. J.
Tel. 3-3000

STANDING COMMITTEES

Meetings at the call of the Chairmen

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HARRY R. NORTH, *Chairman* (1951) ..... Trenton
THOMAS B. LEE (1947) ..... Camden
WILLIAM F. COSTELLO (1949) ..... Dover
HERSCHEL PETTIT (1948) ..... Ocean City
DAVID B. ALLMAN (1950) ..... Atlantic City
L. SAMUEL SICA (1952) ..... Trenton
GEORGE J. YOUNG, *Ex-Officio* ..... Morristown

Medical Defense and Insurance
CHRISTOPHER C. BELING, *Chairman* (1949) ..... Newark
J. WALLACE HURFF (1947) ..... Newark
GEORGE T. TRACY (1947) ..... Beverly
ROBERT L. McKIERNAN (1948) ..... New Brunswick
WAYNE W. HALL (1949) ..... Paterson

Publication
HENRY C. BARKHORN, *Chairman* (1948) ..... Newark
J. LAWRENCE EVANS (1947) ..... Woodcliff
LEWIS W. BROWN (1949) ..... Newark
FRANK G. SCAMMELL, *Ex-Officio* ..... Trenton
ALFRED STAHL, *Ex-Officio* ..... Newark

Scientific Work
First District—JOHN W. GRAY (1949) ..... Newark
Second District—WM. W. MAVER, *Chm.* (1950) ... Jersey City
Third District—PATRICK H. CORRIGAN (1951) ..... Trenton
Fourth District—S. EMLEN STOKES (1947) ..... Moorestown
Fifth District—HAROLD S. DAVIDSON (1948) .... Atlantic City
JOHN H. ROWLAND (1947) ..... New Brunswick
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RALPH K. HOLLINSHED (1947) ..... Westville
SPENCER T. SNEDECOR (1948) ..... Hackensack

Woman's Auxiliary
WILLIAM E. DODD, *Chairman* (1947) ..... Beach Haven
LOUIS SCHNEIDER (1947) ..... Newark
HAMMELL P. SHIPPS (1948) ..... Delanco
L. SAMUEL SICA (1948) ..... Trenton
ILY R. BEIR (1949) ..... Atlantic City

Post-Graduate Education
HENRY B. DECKER, *Chairman* (1949) ..... Camden
ALBERT W. PIGOTT (1948) ..... Skillman
SAMUEL A. COSGROVE (1949) ..... Jersey City
CLARENCE W. WAY (1947) ..... Sea Isle City
ERNEST F. PURCELL (1947) ..... Trenton
WILLIAM F. COSTELLO ..... Dover

Annual Meeting
HARROLD A. MURRAY, *Chairman* (1949) ..... Newark
THOMAS McG. BRENNOCK (1947) ..... Jersey City
CLARENCE L. ANDREWS (1947) ..... Atlantic City
JOHN W. GRAY (1948) ..... Newark
JOHANNES F. PESSEL (1949) ..... Trenton

Scientific Program
THOMAS McG. BRENNOCK, *Chairman* ..... Jersey City
ANDREW J. V. KLEIN ..... Newark
FRANCIS M. CLARKE ..... New Brunswick

WELFARE COMMITTEE

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WALTER E. D'ARCY ..... Trenton
L. SAMUEL SICA ..... Trenton
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JOHN H. ROWLAND ..... New Brunswick
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GRANVILLE L. JONES ..... Marlboro
STANLEY NICHOLS ..... Long Branch
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SALVATORE GIORDANO ..... Morristown
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ADOLPH TOWBIN (Ocean County) ..... Lakewood
HOMER H. CHERRY (Passaic County) ..... Paterson
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JOSEPH R. JEHL ..... Clifton
CHARLES J. MURN ..... Paterson
FRANK L. PERRY (Salem County) ..... Woodstown
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EARL S. HALLINGER (Medical Examiners) ..... Trenton
MR. WILLIAM H. MACDONALD (Health) ..... Trenton
FREDERIC J. QUIGLEY (Legislation) ..... Union City

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J. WALLACE HURFF ..... Newark
GARNETT SUMMERILL ..... Camden
THOMAS J. WALSH ..... Elizabeth
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ASHER YAGUDA ..... Newark
GEORGE BLACKBURNE ..... Newark
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CHESTER I. ULMER ..... Gibbstown
W. JAMES MARQUIS ..... East Orange
WILLIAM K. HARRYMAN ..... Hackensack

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STANLEY NICHOLS, *Vice-Chairman* ..... Long Branch
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WILLIAM O. WUESTER ..... Hillside
JEROME KAUFMAN ..... Newark
ELBERT S. SHERMAN ..... Newark
H. EUGENE READING ..... Paterson
ROBERT A. MACKENZIE ..... Asbury Park
HENRY A. COTTON, JR. ..... Trenton
S. WILLIAM KALB ..... Newark
HAROLD F. TIDWELL ..... West New York
CHRISTIAN P. SEGARD ..... Leonia
ABRAHAM E. JAFFIN ..... Jersey City
ROBERT L. MCKIERNAN ..... New Brunswick
C. BYRON BLAISDELL ..... Long Branch
JAMES O. HILL ..... Newark

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MR. WILLIAM H. MACDONALD (Health) ..... Trenton
EMIL FRANKEL, Ph.D. (Institutions and Agencies) ..... Trenton
MR. JOHN J. DEBUS (Pharmaceutical) ..... Trenton
MRS. STEPHEN W. WATERBURY (Welfare Council) ..... Hillside
MARY M. MUCKLEY (Nurses) ..... Fairlawn

Public Relations

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ROYAL A. SCHAAF ..... Newark
WILLIAM H. MCCALLION ..... Elizabeth
CHARLES J. MURN ..... Paterson
RICHARD T. BUCKLEY, JR. ..... Hightstown
ARTHUR PEACOCK ..... Moorestown
ALBERT B. KUMP ..... Bridgeton
HENRY A. DAVIDSON, *Executive Secretary* ..... Trenton

ADVISORY COMMITTEES TO THE SUBCOMMITTEE ON PUBLIC HEALTH

Meetings at the call of the Chairmen

Adult Disease Control

EDWARD C. KLEIN, JR., *Chairman* ..... Newark
RALPH K. HOLLINSHED ..... Westville
JOSEPH W. GARDAM ..... Newark

Cancer Control

WILLIAM O. WUESTER, *Chairman* ..... Hillside
OTTO R. HOLTERS, *Vice-Chairman* ..... Asbury Park
THOMAS B. LEE ..... Camden
LEONID S. SNEGIREFF ..... Trenton
JOSEPH I. ECHIKSON ..... Newark
W. JAMES MARQUIS ..... East Orange
H. WESLEY JACK ..... Camden
JOSEPH H. KLER ..... New Brunswick

Consultant

EMIL FRANKEL, Ph.D. ..... Trenton

Cardio-Vascular Disease

JEROME G. KAUFMAN, *Chairman* ..... Newark
HARVEY M. EWING, *Vice-Chairman* ..... Montclair
CLARENCE L. ANDREWS ..... Atlantic City
PAUL A. KENNEDY ..... Englewood
THOMAS J. WHITE ..... Jersey City
LEROY W. BLACK ..... Rutherford
EVELYN HOLT ..... Summit
NICHOLAS A. ANTONIUS ..... Newark
FRANK J. ALTSCHUL ..... Long Branch

Child Health

STANLEY NICHOLS, *Chairman* ..... Long Branch
HARROLD A. MURRAY, *Vice-Chairman* ..... Newark
ERNEST G. HUMMEL ..... Camden
WALTER B. STEWART ..... Atlantic City
GEORGE M. LEVITAS ..... Westwood
L. CHARLES ROSENBERG ..... Newark

Consultants

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L. C. VICTOR DUBUSC ..... Elizabeth
ARTHUR F. ACKERMAN ..... Summit
WILLIAM F. MATTHEWS ..... Montclair
IRVING OKIN ..... Passaic
WALTER L. MITCHELL, JR. ..... Newark
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KENNETH BLANCHARD ..... East Orange
FREDERICK H. VONHOFE ..... East Orange
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FREDERIC W. LATHROP ..... Plainfield
WILSON GUTHRIE ..... Newark
JULIUS LEVY ..... Orange
J. M. WISAN, D.D.S. ..... Trenton

Conservation of Vision and Hearing

ELBERT S. SHERMAN, *Chairman* ..... Newark
HALVOR L. HARLEY ..... Atlantic City
REINOLD W. TERKUILE ..... Ridgewood
JAMES S. SHIPMAN ..... Camden
ENOCH BLACKWELL ..... Trenton
JOSEPH H. KLER ..... New Brunswick
JACOB J. MANN ..... Perth Amboy
R. WINFIELD BAESEMAN ..... Asbury Park
CHARLES H. SCHLICHTER ..... Elizabeth

Crippled Children

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FREDERICK G. DILGER, *Vice-Chairman* ..... Hackensack
LEOPOLD SZERLIP ..... Newark
TOUFICK NICOLA ..... Montclair
PAUL J. FINEGAN ..... Trenton
DAVID B. ALLMAN ..... Atlantic City

Maternal Welfare

ROBERT A. MACKENZIE, *Chairman* ..... Asbury Park
ALFRED MEURLIN, *Vice-Chairman* ..... East Orange
J. CARLISLE BROWN ..... Atlantic City
HOWARD C. CURTIS ..... Moorestown
SAMUEL A. COSGROVE ..... Jersey City
HERSCHEL S. MURPHY ..... Roselle
ALFRED D. SUMMERS ..... Princeton
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JOHN E. DAVIS ..... Trenton
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CLARENCE B. WHIMS ..... Ventnor
JAMES T. DODGE ..... Trenton
BENJAMIN I. SASLOW ..... Newark

Tropical Diseases

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ARTURO R. CASILLI ..... Elizabeth

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LESLIE A. STAUBER (Zoologist) ..... New Brunswick
ARTHUR P. RICHARDSON (Pharmacologist) .... New Brunswick
EDWARD HENDERSON (Pathologist) ..... Bloomfield

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ELI RUBENSTEIN ..... Bayonne
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WALTER E. D'ARCY ..... Trenton

Tuberculosis

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JOHN E. RUNNELLS ..... Scotch Plains
HAROLD S. HATCH ..... Morristown
RUFUS R. LITTLE ..... Oradell
MARCUS W. NEWCOMB ..... Browns Mills
CHARLES L. SILK ..... Perth Amboy
LEO B. DRAKE ..... Franklin
CLYDE M. FISH ..... Pleasantville
JOSEPH A. SMITH ..... Glen Gardner
MARTIN H. COLLIER ..... Lakeland
A. JOSEPH HUGHES ..... Camden
HOMER H. CHERRY ..... Paterson

Venereal Disease Control

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AMES L. FILIPPONE ..... Newark
WALTER E. LONGSHORE, JR. ..... Orange
IRWIN B. MARKOWITZ ..... Jersey City
IRVING LERMAN ..... Elizabeth
MAURICE H. AXILROD ..... Atlantic City
HERMAN H. HOLT ..... Paterson

ADVISORY COMMITTEES TO THE SUBCOMMITTEE ON MEDICAL PRACTICE

Meetings at the call of the Chairmen

Anesthesiology

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ARCHER C. BUSH, *Vice-Chairman* ..... Montclair
JACOB D. GOELLER ..... Irvington
LEO J. FITZPATRICK ..... Englewood
NICHOLAS PALMA ..... Paterson
LESTER W. NETZ ..... Hackensack

Contract Practice

ANDREW C. RUOFF, *Chairman* ..... Union City
GEORGE H. VAN EMBURGH ..... Arlington
LEO H. SALVATI ..... Westfield
MATTHEW F. URBANSKI ..... Perth Amboy
ARTHUR G. PRATT ..... Camden

Distribution of Medical Care

ROBERT M. GRIER, *Chairman* ..... Pleasantville
EDWARD GUION ..... Northfield

Hospital Relationships

WATSON B. MORRIS, *Chairman* ..... Springfield
EARL H. SNAVELY ..... Newark
GEORGE O'HANLON ..... Jersey City
J. HARRIS UNDERWOOD ..... Woodbury

Industrial Health and Hygiene

J. MALLORY CARLISLE, *Chairman* ..... Westfield
ARTHUR F. MANGELSDORFF ..... Martinsville
EDGAR E. EVANS ..... Penns Grove
AUGUSTUS GIBSON ..... Mendham
DONALD O. HAMBLIN ..... Martinsville

Laboratory Medicine

ASHER YAGUDA, *Chairman* ..... Newark
A. HOBSON DAVIS ..... Paterson
SAMUEL A. GOLDBERG ..... Newark
FRANK W. KONZELMANN ..... Atlantic City
CARLOS A. PONS ..... Asbury Park

Medical Care of the Indigent

GEORGE BLACKBURNE, *Chairman* ..... Newark
J. WALLACE HURFF ..... Newark
BENJAMIN A. FURMAN ..... Newark
PAUL H. HOSP ..... Newark
HAROLD C. COX ..... Hightstown

Consultant

NORMAN M. SCOTT ..... Newark

Nursing and Nursing Education

A. CHARLES ZEHNDER, *Chairman* ..... Newark
WALTER E. D'ARCY ..... Trenton
H. WESLEY JACK ..... Camden
HOMER I. SILVERS ..... Ventnor
WILLIAM T. READ, JR. ..... Camden

Pharmaceutical Problems

CHESTER I. ULMER, *Chairman* ..... Gibbstown
VICTOR G. HAURY ..... Audubon
ALBERT B. KUMP ..... Bridgeton
REEVE L. BALLINGER ..... Arlington
DANIEL F. REMER ..... Mt. Holly

Physical Medicine

BROR S. TROEDSSON, *Chairman* ..... Orange
MICHAEL J. O'CONNOR ..... Newark
JOSEPH F. A. RUBACKY ..... Passaic
ELMER J. ELIAS ..... Trenton

Radiology

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JOHN L. OLPP ..... Englewood
HARRY J. PERLBERG ..... Jersey City
PHILIP S. AVERY ..... Bound Brook
HARRY R. BRINDLE ..... Asbury Park

Workmen's Compensation

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**Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60; Proc. Soc. Exp. Biol. and Med., 1934, 32, 241; N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.*

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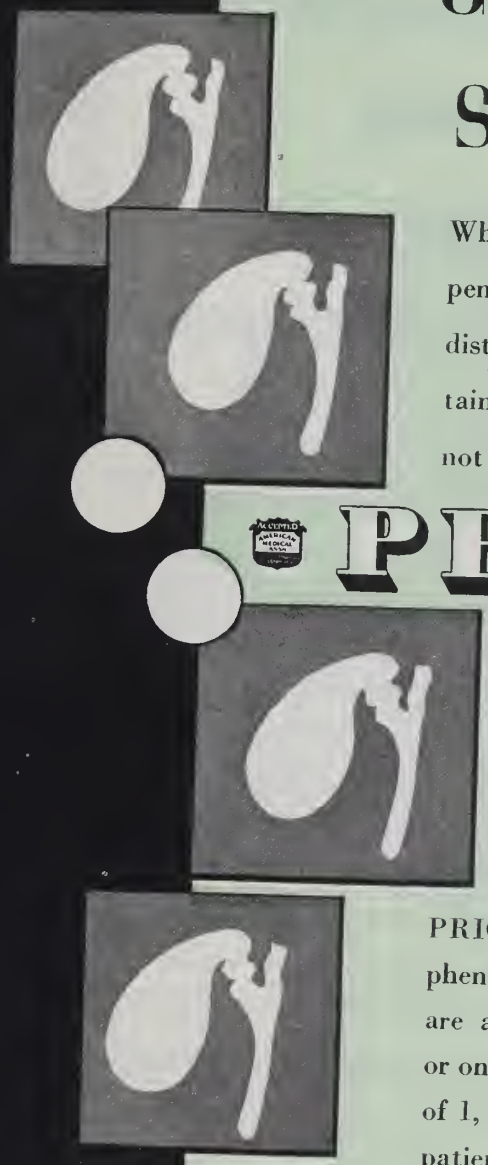
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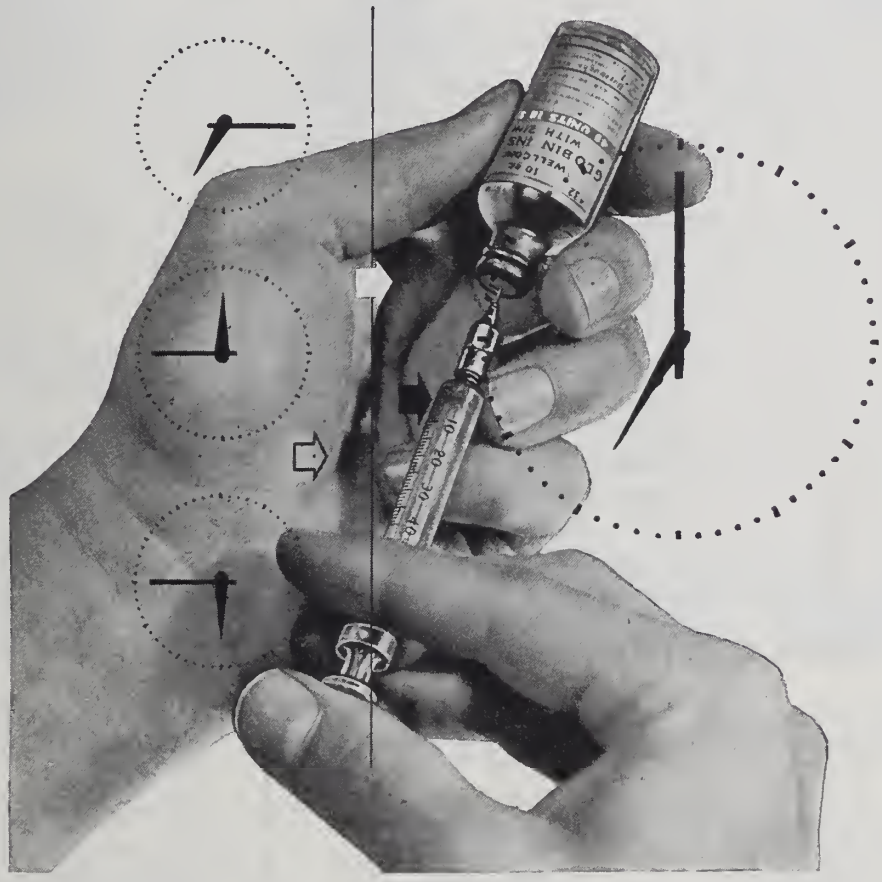
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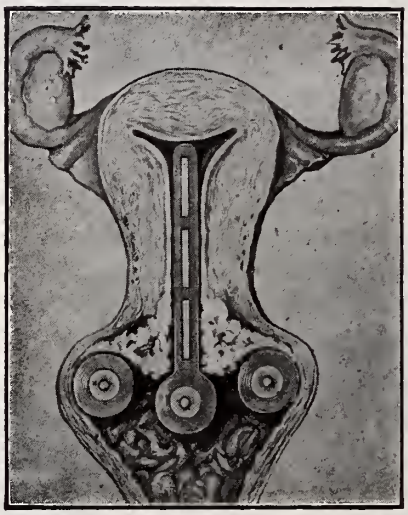
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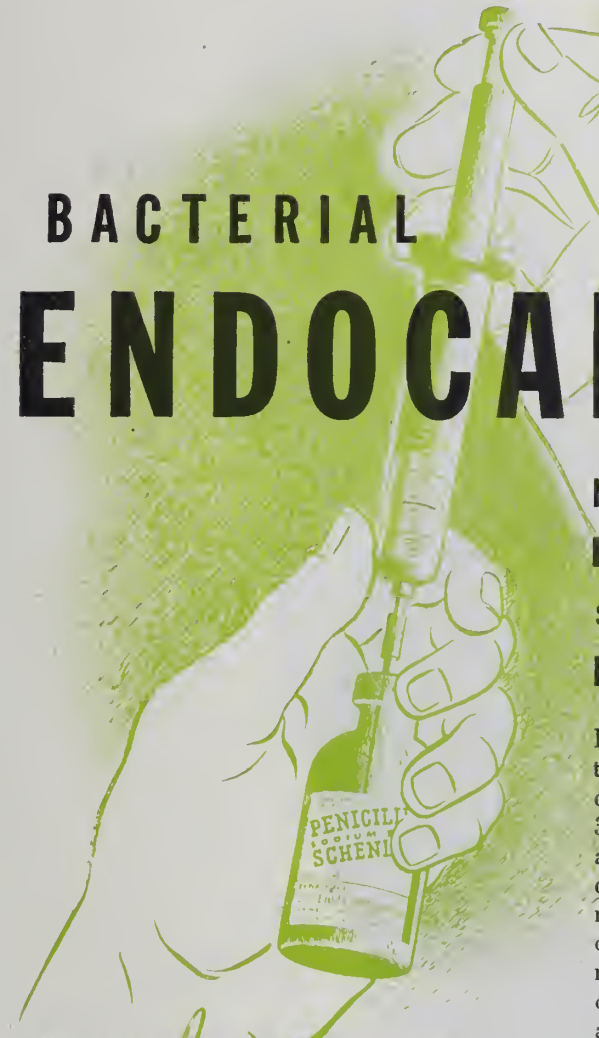
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DAWSON, M. H., AND HUNTER, T. H.: *The Treatment of Subacute Bacterial Endocarditis with Penicillin: Results in Twenty Cases, J.A.M.A. 127:129 (Jan. 20) 1945*. . . FAVOUR, C. B.; JANEWAY, C. A.; GIBSON, J. G., II, AND LEVINE, S. A.: *Progress in the Treatment of Subacute Bacterial Endocarditis, New England J. Med. 234:71 (Jan. 17) 1946.*

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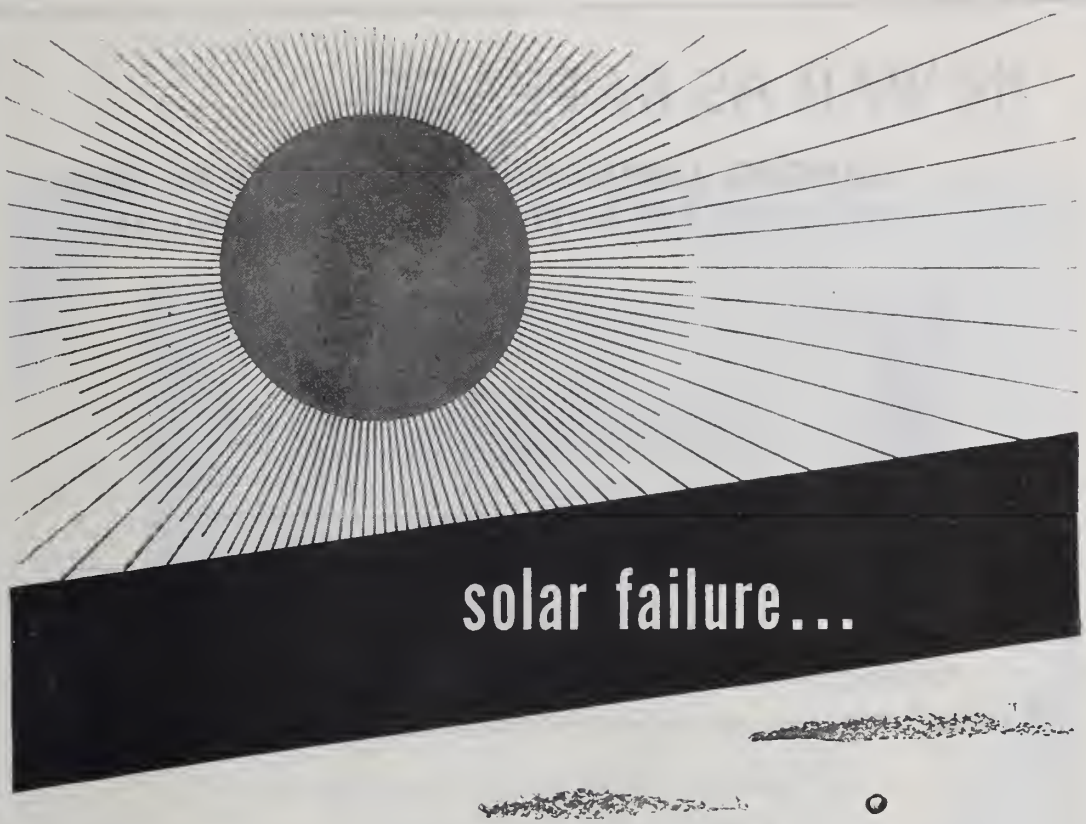
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1. Florida Health Notes 37, May, 1945.
2. Am. J. Dis. Child. 54:1227, 1937.

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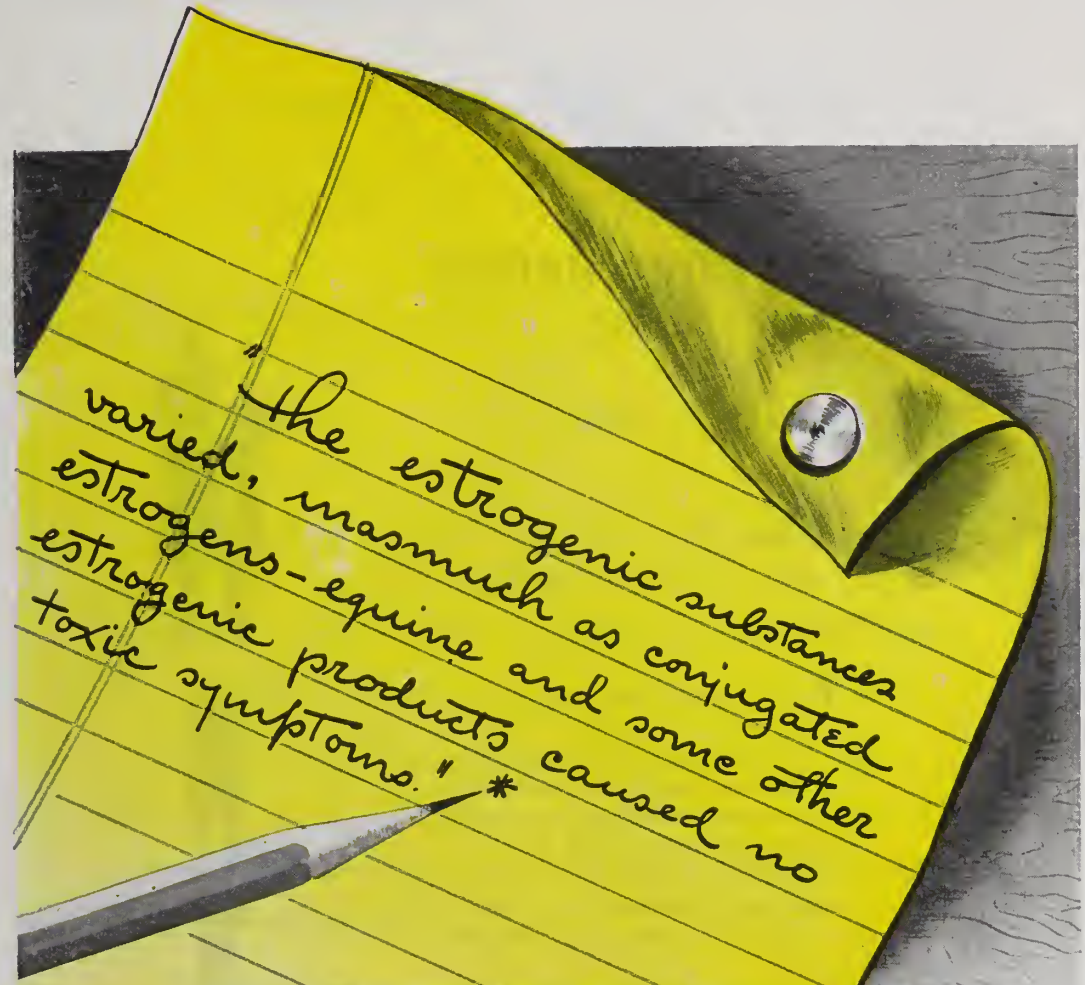
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*Harding, F E.: Am. J. Obst. & Gynec., 51:660 (May) 1946

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Doubting Thomas...

and Richard...

and William...

and James...









Yes, they are all "Doubting Thomases," these Abbott control technicians, when it comes to testing Abbott Intravenous Solutions. They insist upon rigid tests and searching examinations throughout *each step* of manufacture to insure utmost purity and sterility. Starting with the selection of raw materials in the stockroom, their exacting control on each lot is not relaxed until after it is packed and ready for shipment. In the interim, they make sterility and pyrogen tests, with special pharmacological and biological tests when needed; pH determinations; tests for dissolved chemical impurities; light-inspections of each finished container for color, clarity and freedom from foreign particles. If any of these tests should indicate that the lot is not up to standard, the entire lot would be destroyed. As a final precaution, each cap is vacuum-tested to insure an airtight fit. These tests and controls are your assurance that you can use Abbott Intravenous Solutions in bulk containers with fullest confidence. ABBOTT LABORATORIES, North Chicago, Illinois.

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Abbott Intravenous Solutions

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Indicated therapy in Sequelae of

Epidemic Encephalitis

Pills Stramonium (*Davies, Rose*)

2½ grains

Physicians in private practice as well as in neurological clinics have widely prescribed these pills since 1929, and their continued interest in and use of them point to the serviceability of this therapy.

Stramonium Pills (*Davies, Rose*) exhibit in each pill 2½ grains of alkaloidally standardized Stramonium (powdered dried leaf and flowering top of Datura Stramonium, U.S.P.), equivalent to 25 minims (1.54 cc.) of Tincture U.S.P.

As a reassurance of the activity of the finished pills, they, too, are alkaloidally assayed, thus establishing as far as possible uniformity and dependability.

A package for clinical trial and literature mailed free of charge upon request.

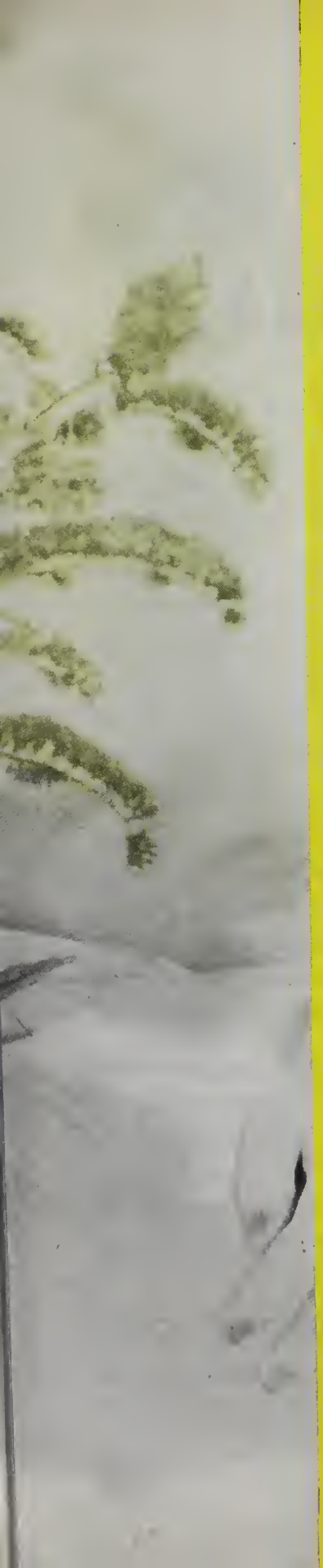


Davies, Rose & Company, Limited

Manufacturing Chemists, Boston 18, Massachusetts

St-1





Three drops of PRIVINE... and welcome relief!



Hay fever sufferers are finding prolonged symptomatic relief with minimal dosage—only three drops—of Privine, Ciba's potent vasoconstrictor.

Privine Hydrochloride acts quickly on the nasal mucosa without retarding ciliary activity. The solution is buffered to a pH of 6.2, closely simulating normal nasal secretions.

Physicians will find that by advising their patients to use no more than the recommended three drops in each nostril, no oftener than three times daily, gratifying and prolonged relief will be experienced.

PRIVINE is available in two solutions, 0.1 per cent and 0.05 per cent, packaged in 1-ounce bottle with dropper designed to dispense but three drops —the recommended dose. Also available in bottles of 16 fluid ounces.

PRIVINE NASAL JELLY—Tubes of ⅝ oz., containing 0.05% Privine Hydrochloride.

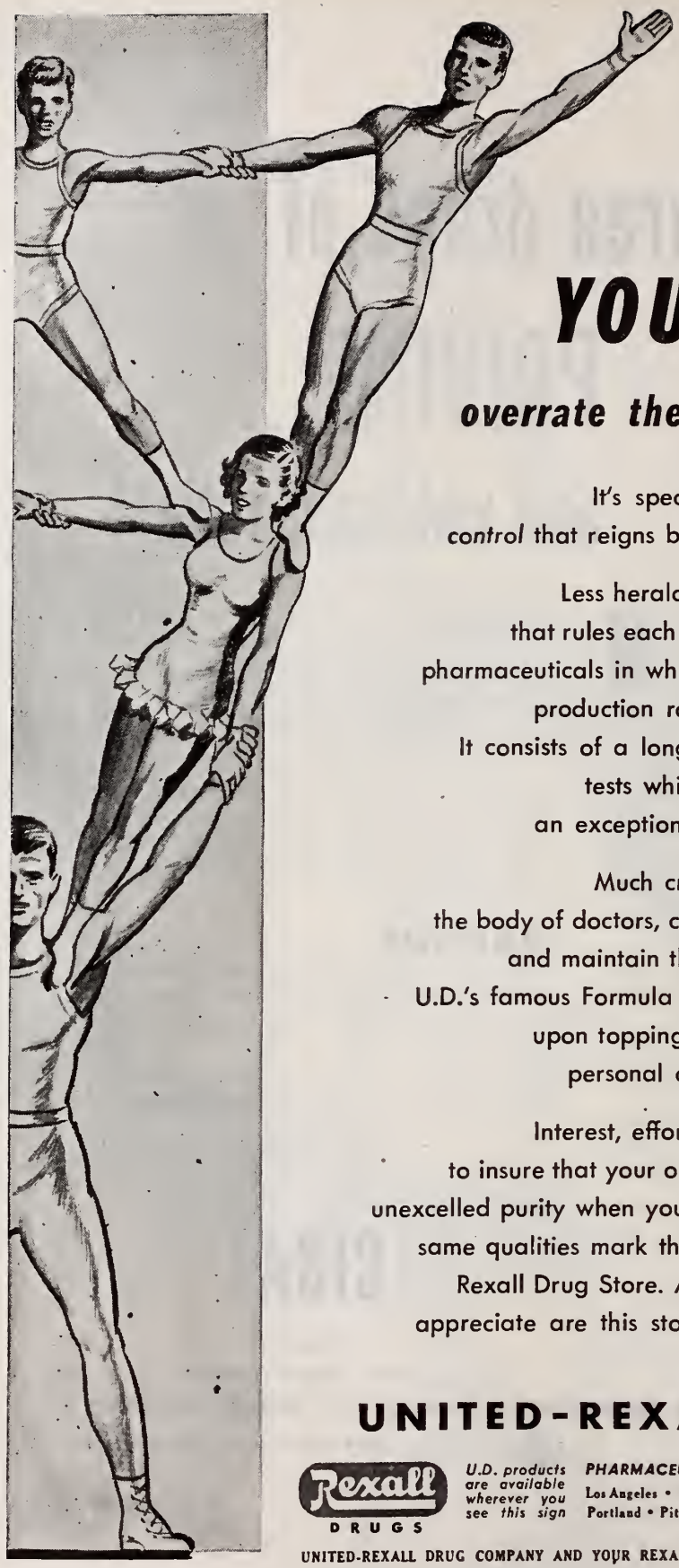
Privine — *Trade Mark Registered in U. S. Pat. Off.*
Brand of Naphazolene Hydrochloride

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Privine is Council Accepted.

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YOU CAN'T

overrate the value of CONTROL

It's spectacular, but brief—the kind of *control* that reigns beneath the big top each Spring.

Less heralded is the day-in day-out control that rules each operation in the manufacture of pharmaceuticals in white-walled U.D. laboratories and production rooms. For this is *quality control.* It consists of a long-established, efficient system of tests which have won for these products an exceptional record for consistent quality.

Much credit for these fine results is due the body of doctors, chemists and pharmacists who set and maintain the high standards. This group is U.D.'s famous Formula Control Committee which insists upon topping all previous precautions with a personal check of every finished formula.

Interest, effort, care and experience combine to insure that your orders are filled with materials of unexcelled purity when you specify U.D. preparations. The same qualities mark the service of your neighborhood Rexall Drug Store. Additional features that patients appreciate are this store's convenience and economy.

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U.D. products are available wherever you see this sign

PHARMACEUTICAL CHEMISTS FOR MORE THAN 43 YEARS

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Postoperative distention and urinary retention may occur despite the most skilful surgical technic. Fortunately, the severe distress of "gas pains," discomfort of catheterization, and the need for enemas and symptomatic therapy may be obviated—and the patient afforded a smoother convalescence—by parenteral administration of one ampul (1 cc) of Prostigmin Methylsulfate* 1:4000 at the time of operation, repeated at 2-hour intervals for a total of 6 injections. Recognition of this fact by leading surgeons has made the prophylactic use of Prostigmin a routine measure in many hospitals.

HOFFMANN-LA ROCHE, INC., Roche Park, Nutley 10, New Jersey

*Neostigmine Methylsulfate

Prostigmin 'ROCHE'



ALL THE NUTRIENTS

Essential for a Food Supplement

Whenever the intake of essential nutrients must be augmented, as in convalescence from surgery or infectious disease, or in the correction of malnutrition, the delicious food drink which results from mixing Ovaltine with milk can be of significant value. This palatable food supplement provides a wealth of essential nutrients in a pleasant, easily assimilated form. It supplies protein of high biologic value, readily metabolized carbohydrate, easily emulsified fat, ascorbic acid, B complex and other vitamins, as well as essential minerals. Three glassfuls daily sharply augments the intake of these nutrients, as shown by the table of composition. Its low curd tension makes for rapid gastric emptying, hence appetite for the next meal is not interfered with. This delicious food drink is enjoyed both as a mealtime beverage and between meals.

THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.

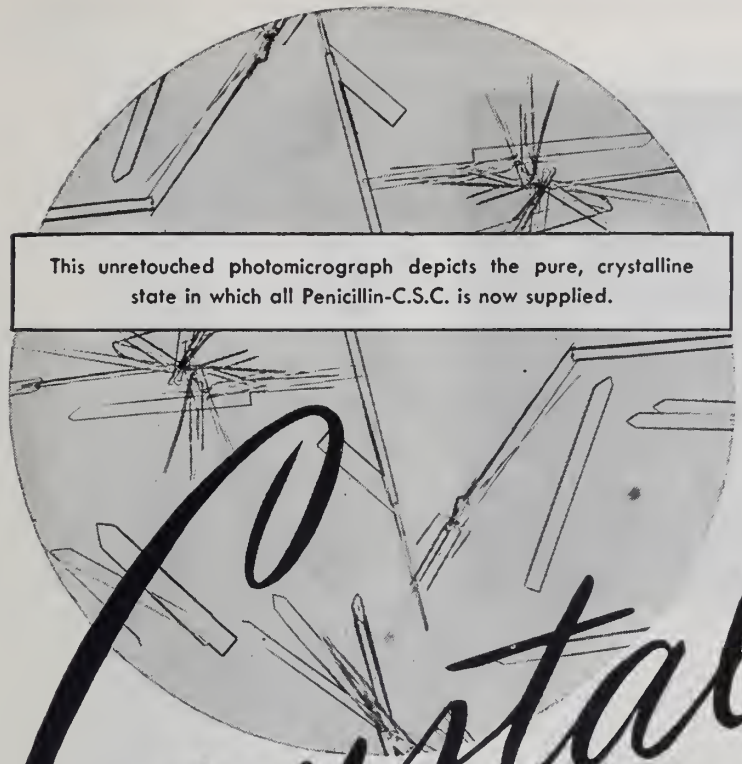


Ovaltine

Three servings daily of Ovaltine, each made of ½ oz. of Ovaltine and 8 oz. of whole milk,* provide:

CALORIES	669	VITAMIN A	3000 I.U.
PROTEIN	32.1 Gm.	VITAMIN B_1	1.16 mg.
FAT	31.5 Gm.	RIBOFLAVIN	1.50 mg.
CARBOHYDRATE	64.8 Gm.	NIACIN	6.81 mg.
CALCIUM	1.12 Gm.	VITAMIN C	39.6 mg.
PHOSPHORUS	0.939 Gm.	VITAMIN D	417 I.U.
IRON	12.0 mg.	COPPER	0.50 mg.

*Based on average reported values for milk.



This unretouched photomicrograph depicts the pure, crystalline state in which all Penicillin-C.S.C. is now supplied.

SYMBOL OF PURITY

Crystalline PENICILLIN SODIUM-C.S.C.

As a result of special processes of purification and crystallization, all Penicillin-C.S.C. is now supplied in the form of the highly purified, heat-stable Crystalline Sodium Salt of Penicillin-C.S.C.

Well Tolerated Subcutaneously

In the crystalline state Penicillin Sodium-C.S.C. is so pure that it can be administered subcutaneously even in large doses with virtually no pain or danger of untoward reactions due to impurities.

No Refrigeration Required

Crystalline Penicillin Sodium-C.S.C. is so heat-stable that it can be kept at room temperatures, virtually indefinitely without losing its potency.* It can now be carried in the physician's bag or stored on the pharmacy shelf. No longer need the physician wait until the patient can be hospitalized or until refrigerated penicillin can be obtained from the nearest depot.

*CAUTION: Once in solution, however, penicillin still requires refrigeration.

Optimal Therapeutic Activity

Because of its high potency per milligram, Crystalline Penicillin Sodium-C.S.C. exerts optimal therapeutic activity. A recent report shows the advantage of highly potent preparations.[1]

Potency Clearly Stated on Label

The high state of purification achieved in Crystalline Penicillin Sodium-C.S.C. is indicated by *its high potency per milligram*. The number of units per milligram is stated on each vial, thus enabling the physician to know the degree of purification of the penicillin he is using.

[1] "The potency of the penicillin undoubtedly affected the results. The first 15 patients, all treated with the same batch of penicillin, were cured. The next 7 patients were treated with the same dosage of a different batch of penicillin. Five of these 7 were not cured. Assays of penicillin used for these 7 patients showed it to be of reduced potency." Trumper, M., and Thompson, G. J.: Prolonging the Effects of Penicillin by Chilling, J.A.M.A. *130*: 628 (March 9) 1946.



Crystalline Penicillin Sodium-C.S.C. is available in serum-type vials containing 100,000, 200,000, or 500,000 units.

ACCEPTED AMERICAN MEDICAL ASSN Council on Pharmacy and Chemistry

Penicillin-C.S.C. is accepted by the Council on Pharmacy and Chemistry of the American Medical Association

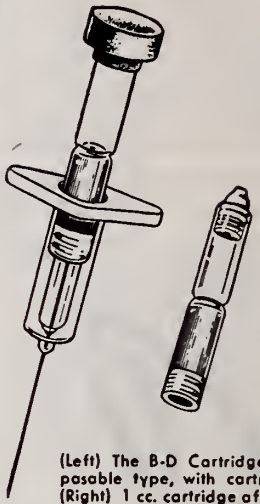
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17 East 42nd Street New York 17, N. Y.

CSC

Announcing
Easier Administration of Penicillin in Oil and Wax



(Left) The B-D Cartridge Syringe, disposable type, with cartridge inserted. (Right) 1 cc. cartridge of penicillin in oil and wax.

The B-D Metal Cartridge Syringe with cartridge inserted.



Bristol Laboratories now introduce two techniques which are designed to make the administration of penicillin easier and more practical. Both of them make use of a 1 cc. glass cartridge of Penicillin in Oil and Wax. A completely new feature of the Bristol Cartridge is a specially designed rubber stopper which permits an aspirating test to prevent venoclysis.

Bristol Cartridges may be used anywhere, any time with the B-D Cartridge Syringe, Disposable Type. (Above) For office or hospital, many physicians will prefer the B-D Metal Cartridge Syringe. (Left)

In addition to the 1 cc. cartridges, Bristol Penicillin in Oil and Wax is still available in 10 cc. rubber-stoppered vials, for those who prefer to employ a Luer-lock syringe. All forms are available through your regular source of supply.

PENICILLIN IN OIL AND WAX BRISTOL

(Romansky Formula)

BRISTOL LABORATORIES INCORPORATED SYRACUSE 1, NEW YORK


BORDEN IS PROUD TO PRESENT
Gerilac
A NEW DIETARY SUPPLEMENT FOR THE AGED
Gerilac basis is milk—nature's most perfect food—modified to provide a high protein and low fat content; with the addition of other dietary factors considered essential in geriatric nutrition . . . so that
Gerilac supplies in one reliquefied pint at least one-third of the protein, a full allowance of each of the vitamins and minerals, and about one-tenth of the calories recommended for daily intake by the Food and Nutrition Board, National Research Council.
Gerilac offers these nutritional values in a palatable, easily consumed and readily digestible form (suitable for use as a beverage or in Special Diets) It also lends itself ideally for the nutrition of convalescents and of pre- and postoperative cases.
NET WT. 1 LB.
Gerilac
MODIFIED MILK FOR SPECIAL DIETARY
Spray dried whole milk skim milk, dried brewer's yeast (source of B vitamins) fortified with riboflavin concentrate, vitamins A and D concentrate from fish liver oil, irradiated ergosteral (vitamin D), ascorbic acid (vitamin C), niacinamide, monosodium phosphate, and iron citrate
Borden's
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PRESCRIPTION PRODUCTS DIVISION
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Write for professional literature
Gerilac—A DIETARY SUPPLEMENT FOR THE AGED. Gerilac contains spray-dried whole milk and skim milk and is fortified with vitamins A and D, B complex, C, together with niacinamide, monosodium phosphate and iron citrate. Available at pharmacies in 1-lb. tins.

The Common Denominator of Reducing Diets

Whether weight reduction is to be brought about gradually, at the rate of a pound or two per week, or drastically at the rate of a pound per day, all reducing diets must recognize one cardinal requirement: the need for protein of the right quality in the right amount.

Unless biologically adequate protein is supplied in the quantity normally required, the living tissue itself would suffer; tissue repair could not be carried on; hemoglobin regeneration would be impaired; antibody formation would be curtailed; resistance to infectious disease would be lessened, and production of enzymes and hormones would fall below the required level

Lean meat may well be called the common denominator of reducing diets. Its protein content is notably high, and the protein it supplies is of high biologic quality, adequate for every protein need.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods and Nutrition

AMERICAN MEAT INSTITUTE

MAIN OFFICE, CHICAGO . . . MEMBERS THROUGHOUT THE UNITED STATES

Effective Against CHIGGERS

(RED BUGS)



SULFUR FOAM APPLICATORS

Convenient Cloth Applicators
Impregnated with Sulfur and Soap

DURING THE COMING SEASON this timely prescription product will bring relief and grateful thanks from patients suffering from chiggers.

Sulfur Foam Applicators are indicated whenever sulfur is to be used externally.

They have the advantage of . . .

. . . even dispersal of fine sulfur particles
. . . convenience—they are easy to use
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. . . safety, minimizing the possibility of sulfur dermatitis

Complete directions with each package

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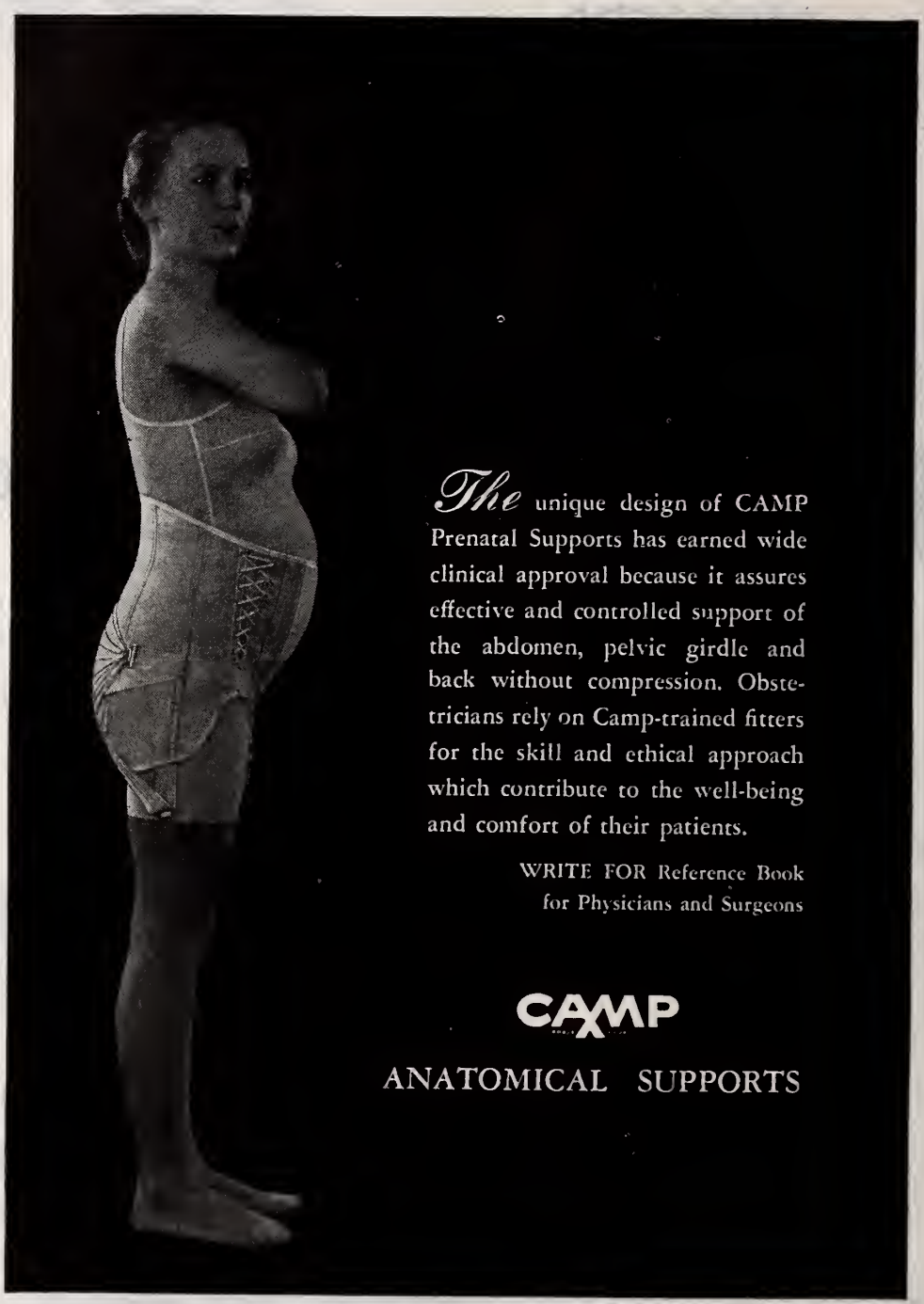
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SULFUR FOAM APPLICATORS

Wyeth
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S. H. CAMP AND COMPANY • Jackson, Michigan

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PLASTIC TRUSSES

For Warm Weather Truss Comfort



Your patients will find comfort and security with the feather-light Plastic Trusses. Ideal for Summer Days. 100% Sanitary. Can be worn in the Ocean.

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SURGICAL AND ORTHOPEDIC APPLIANCES

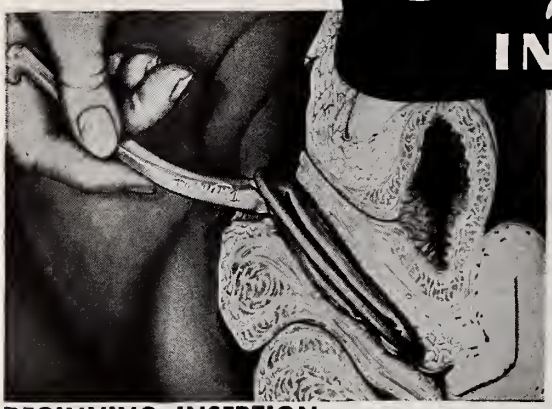
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Male and Female Attendants

Simplicity IN USE

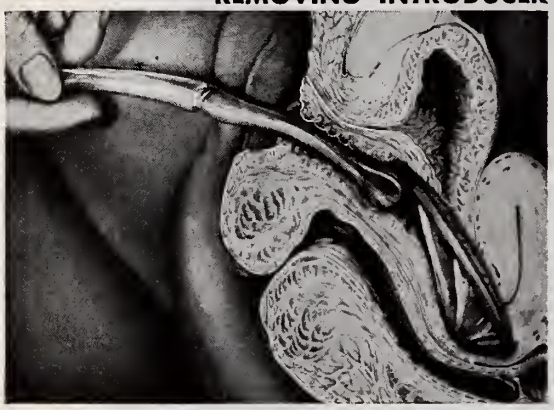


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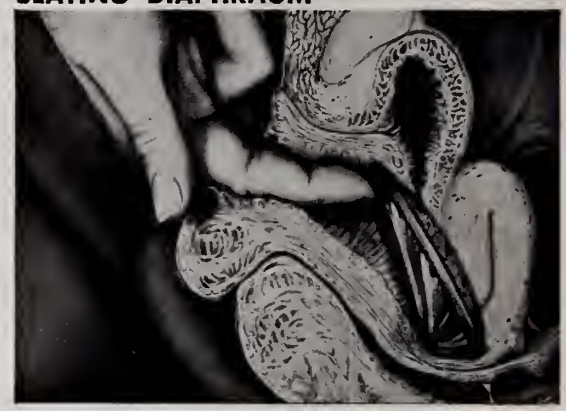


COMPLETING INSERTION

REMOVING INTRODUCER



SEATING DIAPHRAGM



These illustrations, showing the simplicity of use of "RAMSES" Gynecological Products, are reproduced from the booklet *Instructions for Patients*. For the physician's convenience, a supply of these booklets is available, upon request, for distribution to patients.

Determination of indications for control of conception, and advice on the proper method of providing protection, are the exclusive province of the physician. "RAMSES"* Gynecological Products are designed for use under the guidance of the physician only.

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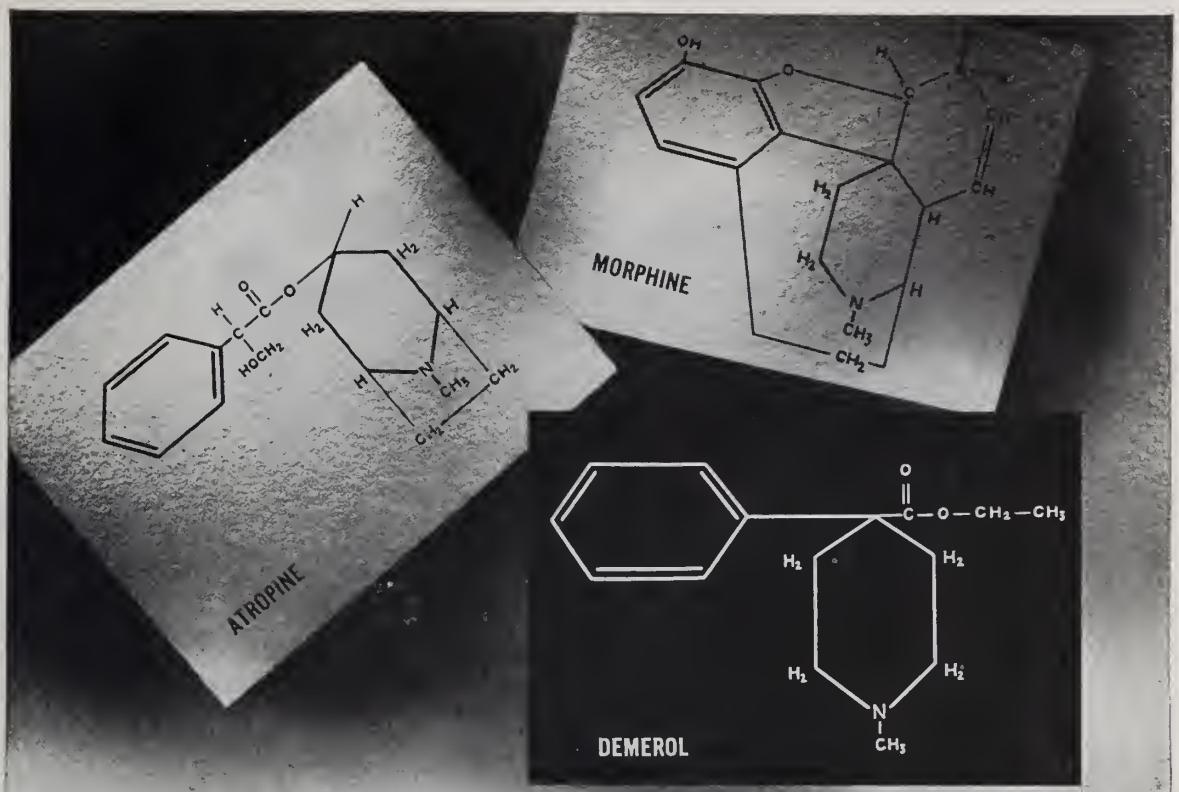
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A MARK OF *Ramses* DEPENDABILITY

gynecological division
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Quality First Since 1883
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Chemical Relationship and Pharmacodynamic Similarity

A NEW SYNTHETIC

ANALGESIC Demerol's analgesic power ranks between morphine and codeine.

SPASMOLYTIC Demerol's spasmolytic action is similar to that of atropine.

SEDATIVE Demerol's sedative effect is mild, but usually sufficient to allay restlessness and induce sleep.

PRACTICALLY NO RISK OF RESPIRATORY DEPRESSION

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DEMEROL
Trademark Reg. U. S. Pat. Off. & Canada
HYDROCHLORIDE
Brand of MEPERIDINE HYDROCHLORIDE
(Isonipecaine)

Average adult dose: 100 mg. orally or intramuscularly.

HOW SUPPLIED — For oral use: Tablets of 50 mg., bottles of 25 and 100. For intramuscular injection: Ampuls of 2 cc. (100 mg.), boxes of 6 and 25, and vials of 30 cc. (50 mg. per 1 cc.).

Subject to regulations of the Federal Bureau of Narcotics

WINTHROP CHEMICAL COMPANY, INC.
Pharmaceuticals of merit for the physician • New York 13 N. Y. • Windsor, Ont.



When amnesia is a blessing

FEAR of the unknown often cruelly grips the patient scheduled for a major operation. At the time when quiet restful sleep is most important, the patient spends the endless night in wakeful dread.

Your patient's precious energy reserve may be saved by the judicious use of 'Sodium Amytal' (Sodium Iso-amyl Ethyl Barbiturate, Lilly). Administered at bedtime, 'Sodium Amytal' encourages forgetfulness and sleep. The moderately long action of 'Sodium Amytal' in most cases insures an uninterrupted night's rest. The patient sleeps soundly, with no thought of what tomorrow may bring. Specify 'Sodium Amytal' for dependable preoperative amnesia and for basal anesthesia.

For detailed information giving comparative data on the various barbiturates, write for the new forty-five-page booklet; *Therapy with the Barbiturates*, A-984.

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Lilly

THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Published Monthly Since September, 1904

Whole Number of Issues, 503

Under the
Direction of the
Committee on Publication

Henry C. Barkhorn, M.D., Chairman

Henry A. Davidson, M.D., Editor

Place of Publication, Printing and Mailing—12 South Day Street, Orange, N. J.
Editorial and Executive Offices of the Society—315 West State Street, Trenton 8, N. J.; Tel. 5776
Send all communications to the Trenton Office.
Each member of the State Society is entitled to receive a copy of The Journal every month.

Vol. 43, No. 7 July, 1946 Subscriptions, $3.00 per Year
Single Copies, 30 Cents

STREAM-LINING THE VETERANS CARE PROGRAM

Hailed by General Hawley as a "model plan", New Jersey's project for the care of veterans by physicians of their own choosing has attracted nationwide attention. Only last month, General Hawley, speaking before the National Tuberculosis Association, reported that when asked by the Kansas Medical Society for a veterans' care program, he told them that their best approach would be to copy the New Jersey plan. This is of course gratifying to the profession in this state, and especially so to Monmouth County, which the Veterans Administration has recognized as the nursery of all such plans. While properly proud of this, we have not been blind to the possibility of improving the plan. And it is with satisfaction that we note recent steps towards this end. To expedite both the authorization of service and the reimbursement of physicians, arrangements are being made with the V. A. which should result in eliminating the bottleneck which developed when all processing had to be funneled through Medical Service Administration. The one danger in short-circuiting the process is, of course, the possibility that without the alert watchfulness of our own Medical Service Administration, the organized profession might lose participation in the selection of physicians and in the distribution of cases. Anticipating this, the new contract will provide for the detailing to the V. A. regional office of one or more of our members to furnish the necessary liaison between the medical profession and the Veterans Administration. As usual, the V. A. has been most cooperative, and the new plan should prove advantageous alike to the veteran, the private practitioner, and the government. It goes without saying that the success of the plan requires the participation of the entire medical profession of New Jersey.

THE DOCTOR AND THE LAY HEALTH AGENCY

Doctors are sometimes disgruntled at the publicity and acclaim which lay health agencies receive. They point out that the public has learned to salute the various lay foundations for their "wonderful work" in combatting tuberculosis, cancer, infantile paralysis and other diseases; and that actually the treatment of the patient is done by the M.D.—an achievement for which he receives little public acknowledgment. However, there is no point in blaming the agency. Their job is to sell the public on the importance of battling a disease syndrome or a health problem, and they do it, and do it well. As a matter of fact most of these agencies are not only willing to accept medical leadership, they are anxious for it. To be sure, their letterheads are often decorated with the names of distinguished physicians. Often this is nothing but window-dressing. The eminent doctors rarely attend a meeting of the board and seldom take active part in implementing the program, except perhaps on the clinical level. Physicians who feel that the good-will which these agencies enjoy has been largely diverted from good-will that should have been focused on the medical profession, are in a position to do something about it. They can accept and maintain vigorous leadership in these civic health organizations.

DO YOU KNOW THE PHARMACIST?

One of the physician's quietest and hardest-working allies is the pharmacist. He imprisons himself in his little store, receives an occasional, and too often patronizing, nod from the passing physician, and tries with unending patience to serve the foibles of a hundred citizens who cross his threshold every day. All he asks of the doctor is some token of recognition that pharmacy is an ancient, scholarly and honorable profession, that sometimes he be given a chance to practice that profession instead of being considered a mechanical transmitter of packaged merchandise and, also please, that prescriptions be written a little more legibly. He hopes you won't put him on the spot by asking him over the telephone to fill an oral narcotic prescription, and he asks that you respect his right to evaluate his own professional fees, as he respects yours. That really isn't asking too much. In return he is in a position to radiate neighborhood good-will towards your office, to procure somehow even the newest drug that the detail man has just extolled, to suggest a pleasant and compatible vehicle for a seldom-used medication, and once in a while to correct those little clerical errors that we all sometimes make on a prescription blank. An occasional visit with the corner pharmacist is worth any doctor's while. So is a joint meeting between the medical and pharmaceutical societies. We are brethren in the healing art. And brothers should know each other better.

ORIGINAL ARTICLES

DIABETES IN PREGNANCY *

Elisabeth B. Ward, M.D., Newark, N. J.

Before the discovery of insulin, diabetes in pregnancy was a rare occurrence. Juvenile diabetics usually died before they attained marriagable age. Many of the older patients had amenorrhea or associated endocrin disturbances which led to sterility or early abortion. Those going to term were a serious problem. William,[1] in 1909, collected 66 cases. He found that eight of the pregnancies resulted in abortion or premature labor and that of those continuing to term 33 per cent resulted in stillbirth, 27 per cent died in labor or within two weeks thereafter and 50 per cent died within two years of delivery. Toxemia occurred in at least half of these pregnancies.

The discovery of insulin changed the picture. Many juveniles now reached the child-bearing age. With insulin, there are fewer cases of sterility and endocrin disorders. Today wherever there is complete control of the diabetes, the risk to the mother is largely eliminated except for the ever-present danger from toxemia which still occurs 50 times more frequently in the diabetic than in the non-diabetic woman.[2]

Glycosuria is not a criterion for diabetes. It is found in about 66 per cent of normal pregnant women,[3] because of lowered renal threshold for glucose; or it may be due to lactose. Lactose is readily differentiated by the fermentation test. True diabetic glycosuria can be determined by blood sugar determination, by tolerance test and the usual symptoms of diabetes; i. e., polyuria, polydypsia and loss of weight. Finding over 140 mg. of glucose per 100 cc. of blood after fasting should lead to a suspicion of diabetes. Tolerance tests are used for confirmation.

To keep a pregnant diabetic completely under control requires the utmost coöperation between patient and physician. The diet must be controlled. White [4] advises 150 to 200 grams of carbohydrate, 2 grams of protein per kilogram of body weight and enough fat to give 30 calories per kilogram. It is generally felt advisable to give fairly large amounts of carbohydrate because of the excessive excretion of sugar in the pregnant woman and the dangers to both mother and fetus from acidosis, glycogen depletion and hypoglycemia. Should excessive gain in weight occur, both the carbohydrate and fat levels of the diet must be considerably lowered.

To utilize this carbohydrate, protamin zinc insulin is given daily. Regular insulin supplements this as needed. While some authorities say that the insulin requirements are decreased during the last trimester, most agree that an increase is needed. White [4] used an average of 21 units of protamin zinc insulin for the first trimester and 30 units during the second and third. In abnormal cases, much larger doses were required. Frequent blood sugars are essential in judging the necessary doses of insulin for each individual.

Two other problems present themselves. Almost 50 per cent of the pregnant diabetic women develop toxemia and only about 60 per cent deliver viable babies. Thus, while insulin has been instrumental in decreasing the maternal mortality, there has been no significant change in the infant mortality.

Cause of toxemia is still unknown. Its incidence in all pregnant women has been lowered by careful prenatal care. Weight gain must be limited to from 20 to 25 pounds. Urine analysis and blood pressures must be checked every 3 to 4 weeks in early pregnancy, every week to ten days in later pregnancy. Diet must be adequate in protein and vitamins, low in fat and

* Read Oct. 26, 1944, at Academy of Medicine of Northern New Jersey.

1. Williams, J. W.: The Clinical Significance of Glycosuria in Pregnant Women. Amer. J. Med. Sciences, 137: 1-26, Jan. '09.

2. DeLee, J. B., and Greenhill, J. P.: Principles and Practice of Obstetrics. Saunders, 1943, p. 520.

3. Beck, A. C.: Obstetric Practice. Williams and Wilkins, 1939, p. 581.

4. White, P., and Hunt, H.: Pregnancy Complicating Diabetes. J. Clinical Endocrinology, Vol 3; 500 511, Sept. '43.

salt and total calories usually under 1500. Additional calcium and iron medication may be necessary. The hemoglobin should be maintained above 70 per cent.

In general, the patient should not be allowed to gain more than 2 pounds per month in early pregnancy, 3 pounds per month during the last trimester. Any sudden gain is a serious indication and, especially in the diabetic, every precaution should be taken to prevent this. Often these sudden gains are caused by fluid imbalance as evidenced clinically by edema. High proteins, low salt and limitation of fluids to 1500 cc. daily will help correct this condition. Where a true pre-eclampsia exists, rapid dehydration is indicated. This can be accomplished by means of magnesium sulfate, 20 cc. of 10 per cent solution, and 50 per cent glucose in doses up to 200 cc. intravenously every 4 to 6 hours.

In addition to sudden gain of weight, rise of blood pressure to more than 140/90 mm., the appearance of albumen in the urine, and clinical symptoms of headache and epigastric pain are danger signs. Every effort should be made to correct the fluid balance and control weight gain. Sedatives may be of help with the hypertension, barbiturates for the mild toxemias. Morphine, often used in eclampsia in the non-diabetic, will mask the symptoms of coma in the diabetic and is best avoided. Hospitalization should not be delayed even in the mild toxemias if the patient does not respond well to ambulatory treatment. In the diabetic, toxemias often become rapidly worse. Danger to the child is much greater than in the non-diabetic.

Recently, a new field of treatment has been promoted which may prove of great value in the prevention and treatment of toxemias. Sixty-one pregnant diabetic women were studied at the George Baker Clinic by White.[5] Her summary is as follows:

"We believe that (1) the abnormal rise of chorionic gonadotropin after the twentieth week to 200 rat units per 100 cc. of blood predicts in the diabetic premature delivery, stillbirth or neonatal death. (2) These accidents are caused by failure of production or metabolism of estrogen and progesterone and (3) they are prevented by continuous substitutional estrogen and progesterone therapy in replacement doses."

Her results were dramatic. It has been impossible for others to use this form of treatment because of the expense involved. Estradiol was used in doses of 150,000 to 450,000 international units and proluton in 10 to 40 mg. doses, daily. However, more recently, diethyl stilbestrol has been used for this purpose. Doses up to 120 mg. daily were used without any side reactions. Bowen[6] reported that he was able to control toxemias using only 6 mg. daily doses. Further study is needed.

The question of type of delivery is still unsettled but in general, spontaneous delivery is now preferred. Caesarian should be done for non-diabetic reasons. An excessively large baby, so frequent in diabetics, or a long closed firm cervix in a primipara, where long labor is anticipated, are often considered sufficient causes for caesarian in the diabetic because of the high incidence of stillbirths in long labors. The fetal heart should be closely observed during labor. At the first sign of fetal distress, instrumental delivery should be considered. New born babies must be carefully watched for evidence of hypoglycemia, which causes many sudden deaths. Often it is necessary to give 10 per cent glucose every two hours by mouth or subcutaneously.

Post-partum course is usually uneventful obstetrically. Most mothers are able to nurse the baby. Sudden changes in insulin requirement often occur so that again blood sugars must be watched frequently to prevent serious accident.

Throughout the whole course of pregnancy, delivery and post-partum periods, both internist and obstetrician must be constantly on the alert for ever-changing problems. Only with the complete coöperation of the patient can a favorable outcome be anticipated.

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ELECTRIC SHOCK THERAPY IN AN ARMY GENERAL HOSPITAL

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The present report deals with observations made during treatment of 200 schizophrenic patients with electric shock in a military hospital. Differences observed in the psychiatric material of civilian and military setting are worth reporting, since mode of onset, environmental factors and duration of psychosis have varied, yet the essential psychosis (schizophrenia) and method of treatment (electric shock) have been the same.

MATERIAL

Most of the patients were soldiers who had developed a schizophrenic psychosis while overseas. A few had been admitted to this hospital while in training in the Zone of Interior. Most had had combat duty, ranging from a few days to several months. Average duration of psychosis was about 12 weeks. In this respect the material differs significantly from that reported from the civilian hospital, where average duration of schizophrenia has been much longer. For my first group of 100 civilian patients it averaged 34½ months, for the second group average duration had been 24½ months.

This is an important prognostic point, since the shorter the duration of schizophrenic psychosis, the better the outlook for improvement. In the military service, an individual is inevitably hospitalized the moment his behavior becomes bizarre to his comrades; unfortunately, in civilian life many psychotics do not come to the attention of psychiatrists for many months, or even years.

None of the present (military) patients had any symptoms of deterioration. According to type of schizophrenia, they were classified as follows: Paranoid, 108 or 54 per cent; catatonic, 48 or 24 per cent; hebephrenic, 18 or 9 per cent; simple, 12 or 6 per cent; mixed type, 14 or 7 per cent; total 200 or 100 per cent.

PROCEDURE

The usual technic of administration of electric shock therapy was employed. The machine manufactured by Offner, Inc., was used in this work. Attempts have been made to avoid petit mal reactions. Treatment was given three times a week. Average course of treatment consisted of 12 generalized convulsive seizures. A few patients required a smaller number of treatments, while some were given 18 to 20 treatments. Occasionally two courses of treatment had to be given. In all patients some gain in weight has been observed, average gains amounting to six pounds. Patients were encouraged to participate in social, physical and recreational activities to aid resocialization in spite of confusion, clouding of the sensorium, and memory defects which arise as a part of electric shock therapy. These confusional states superimposed on the original psychotic picture usually disappear two or three weeks after the last electric shock treatment.

RESULTS

Results of treatment are designated by the terms *apparent remission* and *much improved* for patients who reacted well to the treatment and *slightly improved* or *not improved* for the others. The term *apparent remission* is used in preference to the term "recovered" because the duration of "recoveries" following electric shock treatment is indefinite and relapses are comparatively frequent. The term *much improvement* is used when the patient had no hallucinations or delusions, but still showed some emotional inadequacy.

Patients who were classified as *slightly improved* showed some improvement in behavior but were considered incapable of returning to the work in which they were engaged prior to development of mental illness. In the final analysis they were classed together with the patients who were considered unimproved. Best results were obtained in catatonic patients who were mute, negativistic and refused food. Improvement was marked in patients with strong guilt feelings and suicidal tendencies. Paranoid patients also reacted well to the treatment. Less improvement was noticed in hebephrenic and simple types of schizophrenia.

Of the 200 schizophrenic patients, four weeks after treatment was completed 82 per cent were classified as *much improved* and in *apparent remission,* while only 18 per cent showed no improvement.

In two studies conducted by the author in civilian hospitals * results were markedly inferior and therefore further scrutiny is necessary. Only 32 per cent were considered as *much improved* and in *apparent remission* among the schizophrenics treated with electric shock in a civilian hospital. Approximately the same results have been obtained previously with metrazol.

Several factors are responsible for this situation. In the civilian hospital the author was able to follow up the cases from two to eighteen months until evaluation of the treatment had been made. In a military hospital, patients have to be disposed of in a rapid manner, either by discharge from military service or by transfer to a Veterans' Facility for further hospitalization. Because of impossibility of detaining the patient too long after the active treatment was completed, evaluation had to be made from four to six weeks after the last shock treatment was administered; in most cases at the end of the fourth week. Some patients may have suffered a relapse after returning home.

Psychiatric study of each soldier indicated, in many cases, environmental factors (severe stress of prolonged combat, guilt feelings over aggression, fears of bodily injury or death, witnessing mutilation of friends, necessity for constant submission to authority, feelings of frustration, etc.) which could be considered as precipitating elements in the final psychotic breakdown. Removal from this environment with subsequent evacuation to a hospital in the Zone of Interior must be considered as important contributing factors to the rapid improvement of these patients.

COMPLICATIONS

All patients prior to treatment had complete psychiatric study, physical and neurologic examinations, routine laboratory tests, an electrocardiogram, and roentgenograms of the chest and spine.

To prevent fractures of the spine during treatment, a small sandbag was placed between the shoulders; extremities were held downward without exerting too much pressure. A tongue depressor covered with gauze was kept between the teeth during the convulsive seizure. There were no deaths, no fractures, no dislocations. The fact that over 2000 grand mal convulsive seizures could be produced without any bone injuries speaks against the use of curare, since administration of that drug is not without danger.

Prolonged apnea occurred on many occasions, usually in the same patient, but this did not require injection of stimulating drugs. Using Sylvester's method of respiration or turning head from side to side was sufficient in all cases to restore respiration.

SUMMARY

1. Two hundred schizophrenic soldiers were treated with electric shock in a military hospital; there were no deaths; no serious complications.

2. Results obtained were superior to those in civilian hospital. This is explained by the fact that prognosis is generally better for schizophrenia in military personnel because of shorter duration of the disorder, more sudden onset, and in many cases, presence of definite environmental factors.

3. Electric shock therapy is a valuable adjunct to other methods of treatment of schizophrenic psychosis in military hospitals.

Note: Since this paper was submitted for publication one hundred additional schizophrenic soldiers have been treated by the same method, making a total of three hundred. Essentially the same results were obtained.

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* Reznikoff, L.: Arch. Neur. & Psychiat., 43:318 (Feb. 1940).

The first wealth is health. Sickness is poor-spirited, and cannot serve anyone; it must husband its resources to live. But health answers its own ends, and has to spare; runs over, and inundates the neighborhoods of other men's necessities.—Ralph Waldo Emerson.

THE ROLE OF THE PHYSICIAN IN ADOPTION *

By F. I. Krauss, M.D., Chatham, N. J.

By and large, doctors bypass sociologic questions. They are busy with personal illness and leave spiritual questions to the church and social questions to anyone interested. This attitude is slowly changing, as the correlation between the three fields becomes more intimate in this complex world.

Adoption is a sociologic problem. It is still hit or miss in many areas, even within states with reasonably protective laws. I have had adopted children under my care for over thirty years—the number is growing rapidly. They have come from various states. At the beginning of this period there was no careful investigation by agencies or courts as to the probable future for both parties. The wealthy family often paid well and obtained just what they wanted, those less fortunate fared accordingly. We were often asked, "Where may I find a baby?" and there were few reputable agencies to refer them to, and these had a long waiting list. Then when a child was found, either through an agency or personal contacts, I was asked to examine it, pass on it, do the serologic and other tests. Because of technical difficulties tests were rarely made. Many doctors still know nothing about the progress which has been made by recognized agencies.

Adoption involves two problems: first, the prospective parents, and second, the child to be adopted.

THE PARENTS

The doctor enters into the picture when a family desiring a child comes to him either for his opinion as to the advisability of the proposal, or having taken a child, wish his opinion as to the latter's health and development. Advisability often hinges on whether they have children of their own. There are couples who know before marriage that they will have no children. There are families with their own who desire another; there are those who have waited for years for their own and become discouraged. They may still succeed. The position of a previously adopted child in this latter group would be very important. The doctor's advice in these problems should embrace not the desires of the adults only, but also what may be the future of the child. Do not let the family think they are doing something noble or philanthropic. I have seen this attitude with some who think it is their duty to do something for some poor homeless child. There are plenty of other homes available, and the favor is being done to them also. Families who adopt children, and later have their own, make no distinction between them. The same has applied to families with one or more of their own, who have later adopted another. These people are "natural" parents. Adopted children have more normal lives in these groups than in the family with one adoption only. I am not in favor of the one child family. Multiplicity makes for stability.

Occasionally the doctor is faced with the question of advising parents who have lost their only child on the desirability of adopting another. While this can work out to reciprocal advantage, it is fraught with some danger. They might be the type who so idolized their own child that an adopted child suffers by a comparison, consciously or subconsciously made. Make haste slowly in such a family; give them time for adjustment, and find out if the need is deep seated or if it arises only from temporary loneliness. The family which still wishes a child after a year or two is likely to make a safe home.

We also see homes where there is tension between husband and wife. One or both of them may feel that a child would restore harmony. This is very doubtful. The divorce courts see too many families with children to make this a safe bet. I never advise adoption when conflicts exist. Adults who can not live in harmony as two are certainly going to make three a crowd; and the child becomes the butt of their antagonism.

HEREDITY

The next question in the minds of foster parents is that of heredity. Intelligent people,

* Paper read at the Child Welfare Committee and New Jersey Child Caring Group, Nov. 28, 1945.

young and with good futures, are fearful of the "X" quality in heredity. They give it more thought than their own heredity. A physician who understands the relative rôles of heredity and environment must give advice which is broadminded, comprehensive, and reasonably reassuring.

How important is heredity? Each person is a different combination of genes. A child is likely to "have characteristics similar to those usual in the family to which they belong". It is a risk to adopt a child from an inferior family; and children of superior parents are likely to possess characteristics similar to those common in the family. They are likely to be of better type than those of inferior family stock. Knowing this and taking into account the new environment of which we do have knowledge, we can estimate the chance for the child's development and the family happiness. If the child is markedly deficient in genetic constitution, it will not be influenced materially by environment. Children with good genetic constitutions are readily adaptable to their environment. There are also many children whose constitutions give them strong tendencies in particular directions, special aptitudes, weaknesses, or inborn tastes and tendencies which may be restrained or developed by environment.

Dr. H. S. Jennings states, in Brenneman's Practice of Pediatrics, that, "On the whole, practically all investigators who have made careful study of the relative influence on mentality and character, of heredity and environment, conclude that diversities of heredity have a much greater influence than differences of environment." This statement was a surprise to me until I began to analyze it. It is in line with the old axiom, "It is a wise child that chooses its own ancestors." I am a strong believer in heredity. The more I observe the stress and strain of life, the more I believe that "blood will tell."

The fly in the ointment is that it is difficult to find out much about the heredity. Since many people know little about their own families beyond their grandparents, it is almost impossible to find out much about the forebears of children to be adopted. Many of these are "illegitimate". This may be a social and legal misfortune rather than a biological one. I have seen many beautiful children in this category. This should be explained to the prospective parents. The agency discovers as much as possible, and much more than a private individual could do, and the agency would not recommend adoption of a child showing gross heredity defects without fully acquainting the family with them. I have seen foster parents willingly take a child with a manifest constitutional defect. The trained, skilled social investigator is essential in this field. Of one thing the family physician can be sure; if a child is adopted in New Jersey, an accredited agency of the state has carefully estimated his possibilities from all known data, and matched them with the social, economic and intellectual possibilities in the family. The agency protects the child as well as the family.

AGENCY SUPERVISION

When, after investigation, a child has been placed, parents usually ask the doctor for his opinion of the child. The family with full confidence in the agency make this the last step. Years ago I would have considered this the wrong procedure. I had little respect for the type of investigation being done. It is interesting to observe the difference in attitude today. There used to be fear and uncertainty in the minds of foster parents about the health and heredity of the child. It was for reassurance that they came to the doctor. Now they come with pride and confidence to show the doctor the fine baby they have received. They are usually just as happy, and sometimes seem more so, than if it were actually born to them. Accredited agencies have made this change. Of course they vary in efficiency, but constant improvement is being made. A social worker who is a college graduate, and has had postgraduate work for two or more years in a specialty and holds a degree is worthy of respect by the medical profession.

A physician accustomed to infants and children almost instinctively sizes up the mental and physical development and the emotional stability in a very few moments. A knowledge of what should be expected at certain ages is

essential. Awareness of obscure conditions such as cretinism, thyroid deficiency, arrested hydrocephalus, congenital syphilis, cerebral birth injuries and mental retardation will encourage the doctor to observe closely. The younger the child the greater need for caution. Even emotional instability manifests itself at a very early age. Remember that most of the children we see were not in the best environment before. They were either in a hospital, a foundling home, or with foster parents—and even the finest foster home cannot be the same as a permanent one. Finally, with a good agency, the doctor can be sure the baby was examined before placement by a competent psychiatrist and pediatrician, who were also on the watch for defects.

This is the ideal situation, but it is not always accomplished. Agencies differ in standards, and to illustrate why doctors may have their doubts, I wish to give two illustrations, otherwise you may think I am painting too rosy a picture.

First—Baby A., age one month. She was sent to a family in which there was one other adopted child. She had been in a sectarian hospital, and was in an advanced stage of malnutrition, with vomiting and diarrhea. The prospective mother brought her to me the day she received her from the agency. I was surprised that she had been released, told her the chances of the infant's survival were slim, and asked her to admit the baby to a hospital or return it immediately. However, she decided to take the chance. She followed directions implicity, remained up with it constantly, and succeeded in winning the battle.

Second—Boy B., adopted when ten years of age. The family have one other younger boy adopted in infancy, and wished an older child also. This boy was exhibiting behavior difficulties, was careless, unclean, irresponsible and showed much motor restlessness. There was also congenital maldevelopment. The foster mother had a high standard for children's behavior. However, she took this boy, knowing all about him, with the belief that she could help him become a normal child. He has been with the family for several years, but still manifests many behavior difficulties. This boy should never have been allowed to go to this family, no matter how much the foster parents desired him. Both remain under tension.

Cases of these types emphasize the importance of high standards in agency supervision. One baby seriously ill, another with evident emotional instability. Both were taken by intelligent people, hungry for children. In each case the agency was lax. In the second case particularly, there was little thought given to adjustment. It is these problems which make us cautious. Fortunately as agencies improve their standards and experiences, these examples become exceptions.

THE OUTLOOK

I am optimistic about adoption. I have seen many families whose lives have reached a full cycle, both for the parents and the children, and have seen very few unfortunate results. If this has been true in the past with very little supervision, think how much better it will be in the future as agencies become more proficient through experience and better trained personnel. The time for adoption is when parents are young. They should adopt babies in preference to older children. My greatest problems are among older couples who adopt one child. I would rather place a baby with a young couple in moderate circumstances with the adventure of life before them, than with wealthy older people who are beginning to feel their "aloneness". A child with them is not likely to have a normal life. It is often considered a wonderful thing when a child is adopted by wealthy people. My experience does not justify this broad assumption. Things come too easily to this child, with a consequent softness of character.

The medical profession and the welfare agencies are becoming more closely affiliated in their objectives. Children, as an integral part of the family life of America, are the most important factor in the whole cycle. Intelligent, skilled, highly trained social workers in the field of adoption, plus medical coöperation, can change many a tragedy of birth into a promising future. The physician of this era should be concerned not only with the treatment of and prevention of illness but also with the teaching of a philosophy of life which can be summarized in the phrase, "A sound mind in a sound body".

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THEOPHYLLIN IN THE TREATMENT OF MIGRAINE

A PRELIMINARY REPORT

By ROBERT B. MARIN, M.D., Montclair, N. J.

The enigma of migraine is baffling to the doctor and frustrating to the patient. Headaches, like heartaches, seem to be part of life and can be traced to a variety of causes from indiscretion to organic disease. Suggested causes of migraine include: sinus disorders, toxicity, nerve lesions, endocrine imbalance, blood disorders, and allergy. For treatment, rest, a darkened room, fortitude, and resignation are the usual course. Codeine and morphine are commonly used for relief of severe pain. Ergotamin and inhalations of oxygen and helium have been found of limited value. In the course of exhausting the possibilities of a means of relief for these patients, it was observed that in the treatment of cardiac cases in which theophyllin was used, any headache present was often relieved following the intravenous injection of this drug.

PHYSIOLOGY

The actions of theophyllin are similar to those of its chemical relative, caffeine. It is more potent, however, in relaxing the arteries and has less influence on the nervous system. By virtue of its dilating action on the arteries, it is a frequent remedy in the treatment of coronary thrombosis or spasmodic angina pectoris. According to Leroy,[2] most of the patients treated for these conditions derived only temporary benefit. Greene[1] and his colleagues report the almost uniform relief of dyspnea due to cardiac insufficiency. This is attributed to a marked reduction in the venous pressure which in turn leads to a drop in the cerebrospinal pressure. Favorable clinical reports have been made on the use of theophyllins in bronchial asthma. Lamson and Bacon attribute to theophyllin an antiallergic action, as they have observed beneficial effects in urticaria and allergic rhinitis. However, the exact mode of action has not yet been clearly determined.

On this purely empirical basis, it was decided to try intravenous theophyllin on a group of migraine cases. In each patient, the classical symptoms of migraine were present, and the drug administered only after exhaustive medical examination.

METHOD OF ADMINISTRATION

The patient was allowed to rest fifteen minutes in a darkened room. The procedure and the expected symptoms were carefully explained. Three grains of theophyllin were then slowly administered intravenously. Almost immediately following the beginning of the intravenous injection, each patient experienced the feeling of intense nervousness, flushing, and agitation. These symptoms persisted for about a minute and one-half, then gradually subsided over a period of about ten minutes. Patients were then placed on a daily oral maintenance dose of nine grains of theophyllin. This was gradually reduced over a period of four to six weeks.

CASE REPORT

White female, age 32, had a five-year history of periodic attacks of severe pain, starting in the temporal area and radiating posteriorly; accompanied by tinnitus, dizziness and nausea. The attacks lasted three to five days and occurred at two to three-month intervals. Menstruation was regular, scanty, one to two days in duration, with moderate backache.

Eye grounds were normal. Ears, nose and throat showed no pathology. Teeth were well cared for. Gums do not bleed. The tongue appeared normal. Tonsils had been removed although there is some lymphatic tissue in the posterior pharynx. Basal metabolic rate was minus nine. Heart and lungs were normal, and blood pressure was 90/60. Electrocardiogram was physiologic. The abdomen appeared normal. There was slight tenderness over the right ovary. Reflexes were generally hypoactive. Hair was normal in texture, skin somewhat dry, fingernails brittle.

Pelvic examination revealed second degree retroversion of the uterus, which was painful on motion. A small area of endocervicitis was present on the anterior lip of the cervix.

Rectal examination revealed only tense anal sphincter with one small external hemorrhoid. Blood count and urine analysis were normal.

Within twelve hours of the onset of the next at-

tack, the patient was prepared in the usual fashion and three grains of theophyllin were administered intravenously. Symptoms of increased nervousness, flushing, and agitation occurred almost immediately, persisted about three minutes at the end of which the patient asserted that the pain was completely gone. She was then placed on nine grains of theophyllin daily in divided doses. This was gradually reduced over a period of six weeks. Up to the present time (June 1946), no recurrence has been experienced.

In addition to theophyllin therapy, the patient received liver-stomach concentrate tablets, four daily, and thyroid grains ½, once a day.

Ten cases presenting the classical symptoms of migraine were treated by this method. In seven of the ten patients, no recurrences have been noted. Three patients have had recurrences; each, however, immediately relieved by intravenous theophyllin.

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NOCTURNAL CRAMPS IN LEGS

Nocturnal cramps in the lower extremities, occurring during bed rest and frequently awakening the patient, are not limited to the senile. They occur fairly frequently in pregnant women, especially during the second half of pregnancy. They also may be most annoying to relatively young men and women. The usual phenomenon is muscular spasm with intense discomfort, not dissimilar to the cramps occurring in swimmers and especially in those exerting themselves violently (ineffective, poor or panic stricken swimmers) in cold water. The episodes are closely related both in their subjective distress and in their pathogenesis to the painful attacks in intermittent claudication.

The clinically significant fact is that such cramps arise when the tissue respiration is interfered with, usually as a result of an inadequate local circulation. Two factors other than histanoxia are also clinically significant: the availability of dextrose to the muscle fibers and the concentration of calcium in the blood. Hypoglycemia may induce attacks of angina pectoris; oxygen is relatively useless to working muscle cells unless there is enough dextrose to be oxidized and insulin to catalyse the reaction. This factor is particularly prominent in the pathogenesis of painful muscle cramps in older persons.

Frequently depletion of the blood calcium is associated with a tendency to nocturnal muscle cramps and spasms. Most of these patients admit that they consume almost no milk, the major dietary source of calcium. The hypocalcemia observed in hypoparathyroid tetany is well known. The adrenal secretions are also involved in the control of muscle tone. During the second half of gestation there is a considerable drain on the maternal calcium because of the rapid growth of fetal bone. Oral administration of calcium will in many instances greatly diminish or wholly arrest these recurrent and distressing cramps.

In the elderly, nocturnal cramps are most likely to be associated with impaired circulation due to arteriosclerosis or vascular spasm, with some possibility of nocturnal hypoglycemia as a contributory factor. Though it is commonly assumed that external heat improves the peripheral circulation and that therefore the quiet warmth of the bed should prevent rather than enhance the occurrence of muscular histanoxia, recent studies have convincingly demonstrated that heat increases the metabolic needs, whereas refrigeration decreases the metabolic level, so that if a limb is kept cool a poor circulation may be adequate (Bowers, W. F.: *Mil. Surgeon* 93:289 [Sept.] 1943). It is thus perfectly feasible to consider that the warmth of the bed may contribute to the occurrence of such cramps.

Therapy should wait on as precise a diagnosis as possible. Study of the circulatory efficiency of an extremity, x-ray films to reveal calcification of the major arteries, determination of the fasting blood sugar and blood calcium concentrations should precede the outlining of a therapeutic regimen. — J. A. M. A., Vol. 124, No. 7, p. 471.

BODY FLUID BALANCE

WITH PARTICULAR REFERENCE TO HEART FAILURE

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Under normal conditions, a relationship exists between the fluid contents of the circulatory system and the cells of the tissues whereby adequate and efficient interchange of water, protein, minerals, crystalloids and gases takes place during respiration, combustion and elimination. One is scarcely aware of this mechanism. It is based on osmotic pressure, capillary wall permeability and hydrostatic pressure applicable to the circulatory system. When the body functions efficiently, the first two are of greater importance. Osmotic pressure bears the brunt of responsibility.

OSMOTIC PRESSURE

Osmotic pressure is based primarily on the fact that certain proteins are unable to pass through capillary walls; and as colloids in the circulatory system they exert this osmotic pressure.

At the capillary level where exchange takes place, variable changes of osmotic or oncotic pressure occur on the arteriole and venule sides respectively. On the arteriole limb of the capillary there is a pressure of 20 mm. mercury. On the venous side, it is 12 mm. These are optimal pressures for fluid exchange. When the filtration pressure is greater than the oncotic pressure in the arterial limb, fluid passes from the capillaries into the tissues. When the filtration pressure drops below the level of the oncotic pressure in the venous limb, the direction of flow is back into the capillary. With quantitative reduction of colloids, colloid osmotic pressure is decreased, establishing a lowered filtration pressure so that more fluids pass through the capillaries into the tissues with resultant decreased blood volume. It is the quantitative presence of the colloid proteins within the circulation which determines this relationship. Normally the capillary is relatively impermeable to the protein molecule but permits the free diffusion of the crystalloids circulating in the blood.

The critical level of plasma proteins below which edema will appear is 5.5 grams total protein per 100 c.c. of blood serum or 2.5 grams of albumin. Albumin normally exerts from 2½ to 4 times the osmotic pressure of globulin. Occasionally they may be equal.

EDEMA

Edema usually appears at 15 mm. mercury osmotic pressure in the arteriole limb of the capillary. Edema represents the accumulation of fluid in the body tissues, principally intercellular, or cavities, either subclinical or overt. Basically it is dependent on the phenomena described. Several factors, disease states and mechanical abnormalities may bring this about and the quality, quantity and characteristics of the edema fluid obtained will depend on these factors.

Edema may occur as a result of starvation, decreased nutrition, nephritis, nephrosis, toxic states, nervous influence, local inflammation; arterial, venous and lymphatic stasis due to local or systemic causes; heart failure.

In starvation and nutritional edema, the cause is decreased oncotic pressure because of lessened protein. In nephrosis, the damaged renal tubules are unable to reabsorb albumin, thus reducing the colloid osmotic pressure of the blood.

Increased capillary permeability, particularly as it affects proteins, may result from direct injury to capillary walls, local inflammation or certain bacterial toxins in diseases which have a disposition towards involvement of the circulatory system.

In nephritis, the capillaries are damaged, producing increased permeability. Angioneurotic edema is due to nervous influence and probably involves increased capillary permeability.

Local arterial, venous and lymphatic changes may influence hydrostatic pressure with resultant capillary permeability changes and attendant edema.

CARDIAC EDEMA

Under normal conditions a heart functions efficiently as a pump, propelling blood through the greater and lesser circulation. When heart failure develops, either the left or right ventricle may fail first. Regardless of which chamber fails, eventually, if the process continues, the other fails too. At times, the whole heart may fail at once. Since the preponderance of heart disease affects the left ventricle, the greater circulation usually shows effects earlier.

At best, a normal heart is a 24-hour-working organ. If burdened by added strain, sooner or later, unless death supervenes due to other cause, the heart will fail suddenly or gradually over a variable period of time, dependent on its functional capacity and reserve. With chronic cardiac defects the heart may respond for years by compensatory hypertrophy and dilatation. In acute cardiac disease, the heart may recover completely or partly and carry on with variable compensatory response.

HEART FAILURE

When a heart fails slowly its efficiency as a pump lessens. It functions with decreased output. Gradually, peripheral vascular stasis with variable elevated venous pressure occurs. This static peripheral vascular pooling of blood with attendant effects of gravitation produces an increased hydrostatic pressure within the vessels which eventually alters capillary permeability. A gradual loss of proteins and salt occurs with concomitant shifting of fluids into the interstitial spaces.

Edema fluid in congestive failure (obtained from the extremities and body cavities) has been found to resemble blood serum in content of sugar, nonprotein nitrogen and sodium, containing somewhat more chlorid and less total protein.

While the edema may initially affect only the dependent parts, sooner or later the cavities and remainder of the body become affected.

Obstruction to the portal system due to heart failure produces hepatic, gastric and bowel congestion and stasis with corresponding anorexia, vomiting and diarrhea, indirectly depleting the protein food intake, furthering decreased plasma protein. This lack of protein diminishes iron and red cell production with resultant anemia, furthering cardiac effort.

Although serum proteins in a patient with congestive cardiac failure may seem normal, an insensible loss probably continually occurs. This loss may be furthered by renal congestion and decreased efficiency on the part of the tubules to reabsorb albumin.

Excessive ingestion (or even apparently normal ingestion) of sodium chlorid in the presence of congestive failure may augment edema formation by prerenal deviation. Salt is deposited in the tissues first rather than eliminated primarily through the kidneys and would therefore call for more fluid from the vascular system to produce isotonicity. This is amply borne out by Schroeder's observations on the importance of restriction of salt as compared to water in congestive heart failure. Schemm has recently gone a step further in treating cases of cardiac edema with: (a) high fluid intake orally or by vein, average volume 4000 c.c., (b) a neutral diet to regulate the ingestion of sodium, (c) reduced amounts of salt and sodium since it is the sodium ion which is responsible for furthering the edema and not the chlorid, and (d) an excess of acid-ash by giving small amounts of acid drugs. Not more than half a gram of sodium chlorid should be given per day.

In imminent, progressive or static congestive heart failure, either decreased serum proteins, anemia, sodium ingestion or possibly injudicious fluid intake may aggravate the clinical picture.

THE ABUSE OF REST

Mention must be made of the abuse of immediate and prolonged bed rest in congestive heart failure. In the horizontal position, there is a flow of tissue fluids into the veins and lymphatics producing an increased blood volume and disposition towards furtherance of right ventricular failure, then left. There occurs also a resultant hemodilution, decreased serum concentration and increase in venous pressure. This applies likewise to cases of nocturnal dyspnea with paroxysmal left ventricular failure.

The patient gets most obvious immediate re-

lief by sitting straight up, feet hanging down or even getting out of bed and walking around, thus pooling fluid again in the lower extremities and removing some strain from the right heart. Some help is also afforded by: digitalis preparations; diuretics; raising the thorax by sitting in a chair; extra pillows or back rest in bed; utilizing blocks under the headposts; mild leg exercises and light massage; shifting body position; judicious early use of a commode, and granting of bath room privileges.

Other harmful effects of prolonged bed rest are hypostatic pneumonia, pulmonary embolism, phlebothrombosis and thrombophlebitis, atelectasis, psychic difficulties, prostatic and bladder difficulties.

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177 Livingston Ave.

Has the Annual Number of Deaths in the United States Passed Its Peak?

"We have every reason to hope that for many years to come the excessively high figure for 1918 will not be reached again. In that influenza year the total number of deaths was nearly 1,875,000. In recent years the figure has been of the order of 1,400,000, the year 1940 being slightly in excess of 1939 and 1938. The lowest total of annual deaths since 1918 was experienced in 1921, namely 1,250,000—incidentally, in the same year that saw our all-time highest total of annual births. The growth of our population, with an increasing proportion of older persons, will in all probability eventually cause a rise in the total annual deaths beyond the figure for 1918, in spite of our greatly improved health conditions."—Statistical Bulletin of the Metropolitan Life Insurance Co.

What Is the Average Age at Marriage?

Only a few states publish data regarding the age at marriage. In New York State (exclusive of New York City) average age at first marriage has for a number of years past been about 26 years for men and 23 years for women. The average age for second and higher marriages was 46 for males and 40 for females.

In 1941, the last year for which data are available, more first marriages were recorded as taking place at age 21 than at any other age for brides, and at age 24 for bridegrooms. Only 10 per cent of the bridegrooms were at ages 39 and older, and among these almost two-thirds were marrying for the second time. In the case of the brides, 10 per cent were at ages 34 and older, and three-fifths of these were entering remarriage.—From Statistical Bulletin of Metropolitan Life Insurance Co.

PENICILLIN IN SYPHILIS AND GONORRHEA *

EARLY SYPHILIS

Treatment schedule: Recommended schedule is 40,000 units of penicillin sodium every two hours for sixty doses. (Aggregate dosage is 2,400,000 units.)

Penicillin in Oil and Beeswax (Romansky formula): Reports indicate that this is an effective method of treatment, but it is still in the research stage. Suggested dosage in early syphilis is one injection of 600,000 units daily for eight days, to a total dosage of 4,800,000 units. This material is not supplied by the N. J. State Department of Health.

Combined Therapy (Arsenicals, Bismuth and Penicillin): There is little present evidence to substantiate the suggested synergism between arsenicals and penicillin. The increased patient risk (entailed when arsenicals are used) contraindicates the routine use of arsenicals combined with penicillin.

It might be desirable to follow the penicillin treatment with six to ten injections of bismuth (2 c.c. of insoluble bismuth every week). However, with this form of follow-up treatment relapses may be delayed.

LATE SYPHILIS

Late latent: Recommended dosage is 40,000 units every three hours for a hundred doses. (Aggregate dosage is four million units.) If the patient has cardiovascular syphilis, there is danger of a fatal Herxheimer reaction. If penicillin is used in cardiovascular cases, the patient should receive five or more bismuth injections prior to institution of penicillin therapy.

Neurosyphilis: Recommended dosage is 40,000 units every three hours for 150 doses, to an aggregate of six million units.

Because of budgetary limitations, the State can not furnish penicillin nor reimburse for hospitalization of late latent or tertiary syphilis.

FOLLOW-UP OBSERVATIONS

When penicillin is used in early syphilis, most relapses are revealed during the third, fourth or fifth posttreatment month; rarely later. Follow-up should include quantitative serologic test and physical examination once a month for six months with spinal fluid study at end of sixth month. Further follow-up examinations for a year are desirable; but beyond the sixth month, such follow-ups should be made the responsibility of the patient.

PENICILLIN AND GONORRHEA

Recommended schedule: Aggregate dosage of 200,000 units should be divided into three doses and given at two-hour intervals. If this fails, a second course of 400,000 units should be given.

Penicillin in Oil and Beeswax: Good results have been obtained. Recommended dosage is 300,000 units given as a single injection.

The emulsions (sesame oil-cholesterin, etc.) are still in experimental stages and are not now recommended.

Penicillin tablets orally have been used with beneficial results; however, the cure rate is not as high as when penicillin is given by injection.

Non-specific urethritis is frequently seen following penicillin treatment for gonorrhea. Fifteen to 30 per cent of these patients show "morning drop" for variable periods up to several weeks. These patients are prone to become "genital conscious" and the mere mechanical irritation (by frequent milking of the urethra to produce a drop) is sometimes enough to keep the condition active. When active therapy is desired, mild instillations seem to be the treatment of choice.

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* Developed from a meeting of venereal disease experts held in New York City on May 9, 1946; reported and abstracted here by T. W. McParland, M.D., A. J. Casselman, M.D., and Harold Hendrickson, M.D. Meeting under auspices of United States Public Health Service. This abstract submitted for publication by the Director, N. J. State Department of Health.

STATE ACTIVITIES

VETERANS' CARE PLAN

On March 15, 1946, Medical Service Administration undertook the operation of the Veterans Medical Care Plan under a contract providing that all authorizations for the examination and medical care of New Jersey veterans would be processed through M. S. A., that physicians would return their reports through M. S. A. and that we would then bill V. A. for the authorized services rendered by physicians. It was a simple contract. The plan seemed to be perfectly feasible and to the advantage of both veterans and physicians.

We operated the plan for two months, and established two supplementary offices to accommodate additional clerical force. With this organization we were able to process 300 claims per day, equal to the average number of cases referred to us; but we met with many administrative complications not anticipated under our contract. In issuing the authorizations from our office we were simply repeating the work done by the regional office of V. A. We had no control over the volume of work, or of the type of medical care authorized; and very little control over the standards of medical care rendered. We were but a fifth wheel and a bottle neck in the process of rendering medical care to the veteran.

As the load increased, varying from 50 to 500 claims a day (with as high as 546 returns received in one day), we found it impossible to train adequate clerical help to meet the load satisfactorily and to find adequate office space. This was a defect in our own office. Had we expanded to meet the need we would have formed a large organization at the expense of the Society, with no assurance of self-maintenance; and this large organization would delay rather than facilitate the receiving of medical care by veterans;—in other words it would act as a bottle neck and would serve no useful purpose.

From March 15th to May 15th the total value of services billed the V. A. was $52,414, of which our administrative allowance was $3,700. Our voucher for the remaining period (since May 15th) is now being prepared. The vouchers as we have submitted them have been approved for payment by V. A. and are now in the regional finance office.

Two basic requirements are necessary if the veteran is to received the medical care to which he is entitled under the G. I. Bill. (1) We must have sufficient participating physicians throughout the State to render satisfactory service. and (2) we must have a fee schedule acceptable to the majority of physicians. Both of these basic requirements have been fulfilled by M. S. A.

This is a tremendous task, the like of which we have never before experienced; problems of efficient administration will continue to arise until a satisfactory solution of the problem is found.

To establish an alternate plan many meetings have been held with V. A. representatives. After several evolutionary plans had been evolved, a new contract between M. S. A. and V. A. was submitted to Washington on May 27, 1946. This new contract has the approval of both the regional office and of Dr. Harding, acting for General Hawley. It is still in Washington awaiting official approval.

Under the new contract, the former schedule of fees will apply, the paper work will be done by V. A. regional office; and M. S. A. will delegate a physician for duty in the office of the Chief Medical Officer at the regional office to advise and guide V. A. and protect the interests of the civilian medical profession.

This should prove to be the most satisfactory solution of this problem. It will leave to the medical profession its true function of providing medical care and relieve the profession of the administrative burden of a tremendous governmental bureau. It should protect the interest of private practice and discourage government encroachment in the field of private practice and distribute equitably and on a competitive basis the medical care of the veteran.

M. S. A. is aware of its responsibility to The Medical Society of New Jersey and the medical profession of New Jersey, and will continue its efforts to evolve a satisfactory solution for this problem. During our period of association with V. A. we have had many difficulties and demonstrated many defects in the distribution of medical care to veterans; but our relationship with V. A. has remained most cordial and mutually cooperative.

N. M. SCOTT, M.D.

TRUSTEES' MEETINGS

Annual Meeting of the Board of Trustees was held at 8:00 p. m., May 20, 1946, in Atlantic City. Present were: Dr. Norton, chairman, who presided; Dr. Crowe, Dr. Alexander, Dr. Fithian, Dr. Stahl, Dr. Green, Dr. Londrigan, Dr. Schaaf, Dr. Costello, Dr. Young, Dr. North, Dr. Lee, Dr. Dodd, Dr. Hornberger, Dr. Coleman, Dr. Hawkes. Also present upon invitation were Drs. Sica, Allman, Ballinger, Davidson, Lewis, Scott and Barkhorn. The minutes of the April 7 and May 5 meetings of the Board were approved.

REPORT OF PRESIDENT

President Alexander reported that the New Jersey Health Congress had held several meetings and considerable interest was manifest by the groups represented. A temporary chairman, Dr. Stanley Nichols, and a temporary secretary, Mr. John Hall, have been appointed. The constitution and by-laws for the group is now being drafted and will be presented to the Trustees.

President Alexander stated that he had attended on May 9 the Atlantic States Regional Conference on Medical Service and Public Relations, held in Philadelphia. Attending the Conference were representatives from New York, Pennsylvania, Virginia, Maryland, Delaware, the District of Columbia and New Jersey. A great part of the meeting was devoted to discussion of care of the veteran.

President Alexander reported that he had attended a number of meetings with representatives of the Veterans Administration and Medical Service Administration in an effort to develop a new program for medical care of the veteran with service-connected disabilities. It was not possible to have arrangements completed by this date, but another meeting has been arranged for May 27 and it is hoped that a revised contract will be signed at that time.

REPORT OF FINANCE AND BUDGET COMMITTEE

Dr. North, Chairman of the Finance and Budget Committee, read the itemized budget for 1946-47 and presented the following recommendations from the Committee:

1. That the itemized budget, in the total amount of $71,850, be approved.
2. That the per capita assessment for 1947 be $22.
3. That the bonuses, totalling $2978, as provided in the 1945-46 budget, be approved.
4. That Mrs. Armstrong be given an honorarium of $300 ($100 for past three years) in recognition of her services in carrying on the work of the Editorial Office while the editor was in service.
5. That organizations, outside the medical profession and its auxiliaries, be charged a janitorial fee of $5.00 for each meeting held in the State Society home; this fee to be given to the caretaker as compensation for extra work incurred.
6. That the policy of the State Society to give a dues credit to members in Service be continued for 1947.
7. That members separated from Service after October 1, 1946, be given a dues credit for 1947.

Upon motion by Dr. Schaaf, seconded and unanimously carried, items 1, 3, 4, 5, 6 and 7 of the Finance and Budget Committee report were approved.

Upon motion, seconded and unanimously carried, the per capita assessment for 1947 was set at $20.

REPORT OF THE TREASURER

Dr. Young, treasurer, presented his report, which was unanimously approved by the Trustees. He asked that the Kipp Memorial Fund, which has a total of $38.90, be transferred to the General Fund. Dr. Londrigan moved that the amount presently in the Kipp Memorial Fund be transferred to the General Fund, if legally possible. Seconded by Dr. Costello and unanimously carried.

Dr. Young suggested that the funds contributed to the Scientific Research Fund, which now total, including interest, $316.25, be returned to the contributors, and that the interest be transferred to the General Fund.

Dr. Londrigan moved that the amount presently in the Scientific Research Fund be transferred to the General Fund, with the consent of the contributors. Seconded by Dr. Costello and unanimously carried.

Dr. Young stated that a $1000 U. S. Bond, now held by the Society, will not bear interest after June, and requested authority to invest this money elsewhere.

Dr. North moved that the $1000 U. S. Bond be cashed and the money invested in a Series G Bond. Seconded and unanimously carried.

McBRIDE MEMORIAL FUND

It was reported that the McBride Memorial Fund now totals $1000 in contributions from individual physicians.

COMMUNICATIONS

A communication from the *New Jersey Crippled Children Commission* was read, requesting the recommendation of a member of our Society for appointment on the Commission; the term of the incumbent, Dr. Frederick G. Dilger, expires June, 1946. On motion, unanimously carried, the name of Dr. Frederick G. Dilger was recommended to Governor

Edge for reappointment to the New Jersey Crippled Children Commission, for a term of five years.

The communication from the *Committee on Pharmaceutical Problems,* requesting that the Society donate $500 to the New Jersey Formulary Research Foundation (presented at the meeting on April 7), was reconsidered. Dr. Reeve L. Ballinger, chairman of the Joint Committee on Professional Relations, spoke in support of the Foundation and urged that the contribution be made.

Dr. Alexander moved that $500 be granted, for the ensuing year, to the New Jersey Formulary Research Foundation, to be charged against this year's budget. Seconded by Dr. Londrigan and unanimously carried.

A communication from the *New Jersey Health and Sanitary Association* was presented, inviting The Medical Society of New Jersey to become a member of the Association, and to select two representatives to become members of the General Council of the Association.

Dr. Alexander moved that The Medical Society of New Jersey become a member of the New Jersey Health and Sanitary Association, with dues of $5.00 per year. Seconded by Dr. Lee and unanimously carried.

The Board of Trustees appointed Dr. Stanley Nichols and Dr. C. Byron Blaisdell as representatives of The Medical Society of New Jersey on the General Council of the Health and Sanitary Association.

Chairman Norton read a communication from the *American Medical Association* requesting the appointment in each State Society of a Committee on Military Service.

Upon motion by Dr. Costello, seconded and unanimously carried, the communication from the A. M. A. was tabled until the matter can be given more careful consideration.

HONORARY MEMBERSHIP

Dr. Schaaf suggested that the Constitution be amended to create a class of Honorary Membership which would include persons other than physicians who have rendered a signal service to the Society.

Upon motion it was directed that a proposed amendment to the Constitution, Article IV, Section 5—(Honorary Members) be drafted for presentation to the House of Delegates and referral to the Reference Committee on Constitution and By-Laws.

VETERANS MEDICAL CARE

Dr. Lewis, president of Medical Service Administration, read the following report of Medical Service Administration relative to the Veterans Medical Care Plan.

The Plan for providing medical care of veterans which was approved by the Board of Trustees on January 27, 1946, was placed in operation by Medical Service Administration on March 15, 1946.

Although carefully studied and planned, and thought to be feasible and desirable, certain administrative difficulties became immediately apparent.

By April 21 two main points were apparent: (1) That to handle the work satisfactorily and efficiently, Medical Service Administration would have to build up a large organization capable of dealing effectively with a great mass of detailed paper work. (2) That if such an organization was built up we would function merely by duplicating the work being done in the Regional Office of Veterans Administration. This was carefully considered by the Board of Governors of Medical Service Administration on April 28. It was apparent that the development of such an organization would be difficult, if not impossible, due to inability to procure adequate office space and trained personnel and essential equipment. The great expense, while not an insuperable difficulty, was a factor of importance, and the procurement of necessary funds would have required much careful thought and planning. It was also apparent that such an organization, duplicating the work of the Veterans Administration Regional Office, would serve only to delay the securing of medical care by the veterans; it would produce a bottlneneck which would serve no useful purpose.

Medical Service Administration is aware of the responsibility of The Medical Society of New Jersey for the care of the veteran and believes The Medical Society should maintain close liaison with Veterans Administration; we believe that by the adoption of an alternate plan the administrative work will be expedited to a great degree.

Two essential requirements must be met in solving this problem: (1) The enrollment of sufficient physicians to provide adequate medical care to the veterans of New Jersey (Medical Service Administration has procured the services of over 3,000 members of the Society). (2) The adoption of a schedule of benefits to be made in payment for the services of physicians which is acceptable to the Society and to Veterans Administration (such a schedule which by and large is acceptable to the Society and Veterans Administration has been adopted).

Medical Service Administration, therefore, has met the two essential requirements.

Medical Service Administration proposes an alternate plan which will eliminate delays and alleviate dissatisfaction. We propose that one or more physicians to be known as medical coordinators be selected and assigned to work full time in close liaison with Veterans Administration Regional Headquarters.

The selection of these physicians should preferably be made by The Medical Society of New Jersey. If for legal reasons they must be selected by Veterans Administration their appointment should have the approval of The Medical Society of New Jersey. The officials of the Veterans Administration believe such an arrangement should be satisfactory from their point of view as well as to the physicians of New Jersey. They are willing to accept such a coordinator or coordinators and provide the necessary office space and personnel.

The question of how the coordinator, or cooordinators, are to be paid is the one remaining point

under negotiation with Veterans Administration. We are hopeful, but not sanguine, that a means will be found by which payment may be made to Medical Service Administration by Veterans Administration on a percentage or other basis with which to defray the salary cost of the coordinators.

That the coordinators may function most effectively there should be established within the Society, a Veterans Medical Care Committee, to act as advisers to the coordinators and assist them in solving difficulties which may develop from time to time in the administration of the plan.

Should it develop that government funds cannot be made available to Medical Service Administration for this purpose we strongly urge that The Medical Society of New Jersey assume the responsibility of this expense.

We recommend that an appropriate amount be levied as an assessment against each member of the Society to meet this expense as a separate budgetary item allocated to this use only. We believe that the recommendation of such an assessment can be justified by pointing out that by the above arrangement the interest of all physicians of the state will be protected, that encroachment by government in the field of private practice would be, to a large extent, averted, and on the grounds that a large amount of money would be distributed more equitably among the physicians of the state. We would especially point out the importance and great advantage of this work as a public relations project.

If government funds are made available to Medical Service Administration for the expense of paying the salaries of coordinators and the cost incidental thereto, Medical Service Administration would be obliged to function as the corporate body authorized by law to deal with government. If government funds are not made available to Medical Service Administration for the above purpose we strongly recommend that the Veterans Medical Care Program be handled by the proposed Advisory Committee of The Medical Society of New Jersey, independently of Medical Service Administration. If the responsibility ultimately devolves upon Medical Service Administration, it is suggested that the Governing Board of Medical Service Administration might be appointed as the Advisory Committee on Veterans Affairs.

Upon motion, seconded and unanimously carried, the report of Medical Service Administration was endorsed by the Trustees.

Following lengthy discussion the following recommendations were presented to the Board by the Committee of the Board appointed to consider the Veterans Medical Care Plan:

1. That there be appointed by Medical Service Administration one or more coordinators from the membership of The Medical Society of New Jersey, with the approval of the Board of Trustees of The Medical Society of New Jersey.
2. That this coordinator or these coordinators be selected and paid by Medical Service Administration.
3. That to procure the funds incidental to the operative costs of Veterans' Care Program and to underwrite the cost of a coordinator, a special assessment of $15.00 be levied against each member of The Medical Society of New Jersey for the ensuing year.
4. That this assessment be payable on July 1, 1946.
5. That Medical Service Administration be officially designated as The Medical Society of New Jersey's corporate body in all negotiations with Veterans Administration.

Upon motion by Dr. Alexander, seconded and unanimously carried, the above recommendations of the Board Committee were approved.

The meeting was adjourned at 11:45 p. m.

A meeting of the Board of Trustees was held at 4:00 p. m., May 23, 1946, in Atlantic City.

Present were: Dr. Norton, chairman, who presided; Dr. Alexander, Dr. Crowe, Dr. Scammell, Dr. Schaaf, Dr. Dodd, Dr. Coleman, Dr. Costello, Dr. Londrigan, Dr. Hornberger, Dr. Green, Dr. Young, Dr. Lee, Dr. Stahl, Dr. Fithian, Dr. Hawkes. Also present were Drs. Scott and Barkhorn.

President Alexander expressed his appreciation to Dr. James F. Norton for his excellent cooperation as chairman of the Board of Trustees during the administration just terminated.

The Board of Trustees gave a vote of thanks to Dr. Norton for his service as chairman of the Board of Trustees for the past two years.

The Board of Trustees gave a vote of appreciation to Dr. Joseph F. Londrigan for his activities as a member of the Board of Trustees during the past year.

The 1945-46 Board of Trustees was adjourned *sine die* at 4:10 p. m.

ALDRICH C. CROWE, M.D.,
Secretary.

The reorganization meeting of the Board of Trustees was held on May 23, 1946, in Atlantic City, at 4:10 p. m.

Present were: Dr. Alexander, Dr. Crowe, Dr. Norton, Dr. Scammell, Dr. Schaaf, Dr. Dodd, Dr. Coleman, Dr. Costello, Dr. Green, Dr. Hornberger, Dr. Young, Dr. Lee, Dr. Stahl, Dr. Fithian and Dr. Hawkes. Also present were Drs. Barkhorn and Scott. President Scammell presided until the election of a chairman.

ELECTION OF OFFICERS

Dr. Lee nominated Dr. Aldrich C. Crowe for chairman of the Board of Trustees for 1946-47. Upon motion the nominations were closed and the secretary cast a ballot declaring Dr. Crowe elected chairman of the Board. Dr.

Schaaf nominated Dr. David W. Green for secretary of the Board of Trustees for 1946-47. Upon motion the nominations were closed and the chairman cast a ballot declaring Dr. Green elected secretary of the Board.

RESIGNATION OF DR. NORTON

Dr. James F. Norton, second vice-president, submitted his resignation as a member of the Board of Trustees from the 2d District, effective immediately. Dr. Norton's resignation was accepted upon motion.

ELECTION OF TRUSTEE

To meet the vacancy on the Board from the Second District, Dr. Sigurd W. Johnsen of Passaic was elected to fill the unexpired term of Dr. Norton.

VETERANS CARE COMMITTEE

Dr. Stahl moved that Drs. Norton, Alexander and Schaaf be appointed as a Committee to work with the Medical Service Administration and the Veterans Administration in the Veterans' Medical Care Program. Seconded and unanimously carried.

Dr. Alexander requested that he be relieved as chairman of this committee; subsequently Dr. Schaaf was selected to serve as chairman.

Dr. Hawkes moved that the committee consisting of Drs. Norton, Alexander and Schaaf be declared the Liaison Committee between the Medical Society and the Veterans Administration, called for by the House of Delegates, and that this committee be given power to negotiate with government for an agreement of the veterans medical care program. Seconded by Dr. Stahl and unanimously carried.

REMISSION OF DUES

The resolution from the Essex County Medical Society relative to the remission of dues for delinquent or new members, who are or have been in Service, referred to the Trustees by the House of Delegates, was forwarded to the Finance and Budget Committee, upon motion by Dr. Schaaf, seconded by Dr. Scammell and unanimously carried.

Dr. Crowe and Dr. Green thanked the members of the Board for their election as chairman and secretary, respectively, and assured the Board of their cooperation.

David W. Green, M.D.,
Secretary.

A regular meeting of the Board of Trustees was held on Sunday, June 16, 1946, at the State Society Headquarters, Trenton, at 2:30 p. m.

Present were: Dr. Crowe, chairman, who presided; Dr. Green, Dr. Hawkes, Dr. Costello, Dr. Coleman, Dr. Lance, Dr. Stahl, Dr. Dodd, Dr. Schaaf, Dr. Fithian and Dr. Johnsen. Also present upon invitation were Dr. Weigel, Dr. Quigley, Dr. Lewis, Dr. Barkhorn, Dr. Read, Dr. Davidson and Dr. Scott. Drs. Alexander, Scammell, North, Young and Hornberger were excused.

Chairman Crowe welcomed Dr. Lance and Dr. Johnsen, the new members of the Board of Trustees.

The communication from the A. M. A. requesting appointment in each state society of a committee on military service, held over from the May meeting of the Board, was reconsidered.

Dr. Costello moved that the Chairman of the Board and the President be empowered to appoint the requested committee, to work with the A. M. A. Committee on National Emergency Medical Services. Seconded by Dr. Coleman and unanimously carried.

VETERANS CARE PLAN

Dr. Schaaf, chairman of the Veterans' Liaison Committee, reported that the committee had met with representatives of Medical Service Administration and Veterans Administration on May 27 and negotiated a new contract with the government, and that the committee had circularized the membership to determine if there was, within the Society, a man qualified for the position of Coordinator and Executive Officer of The Medical Society of New Jersey. There have been about 35 applications. The committee has not yet had opportunity to consider these, but a meeting of the committee wil be held soon and it is hoped that a recommendation can be made for the Board's approval. The new contract, which Dr. Schaaf read (on file in the Executive Offices), has been unofficially reported as approved and will be returned very shortly and then become operative.

The committee proposes that a central state liaison committee be appointed, and that each county have a county liaison committee; the state liaison committee to be composed of the chairmen of the county committees with five members of the State Society at large, acting as an executive body of the state committee. The present committee feels that it should serve only in the formative period and that when the plan is running smoothly the Trustee committee should be replaced by the central state liaison committee.

Dr. Stahl moved that the report of the Vet-

erans Liaison Committee be approved and the recommendations concurred in. Seconded by Dr. Coleman and unanimously carried.

CONFERENCE WITH A. M. A. DELEGATES

Dr. Quigley spoke briefly on the following items, which it was felt would be of interest to the A. M. A. Delegates.

1. The A. M. A. has recommended: "A program for national health should include the administration of medical care, including hospitalization, to all veterans; such medical care to be provided preferably by a physician of the veteran's choice, with payment by the Veterans Administration through a plan mutually agreed on between the state medical association and the Veterans Administration." As it now reads the A. M. A. goes on record in favor of a program of national health for all veterans, whether there is a service-connected disability or not. Dr. Louis Bauer of the A. M. A. has said that it was never intended that *all* veterans should be included.

Dr. Quigley suggested that this be amended along the following lines—A program for national health should include the administration of medical care, including hospitalization, *to all war veterans suffering from service-connected disabilities.* . . .

2. At the 1938 special meeting of the House of Delegates of the A. M. A., there was a recommendation in favor of the principle of cash sickness benefits. This stated that the medical profession should be relieved of the duty and responsibility of certification of illness, and that this should be performed by a medical employee of the disbursing agency. This is not practicable, as has been shown in Rhode Island, the only state where there is any experience in a program for cash sickness benefits. Rhode Island has had such a plan since 1942 and recently California has enacted similar legislation.

Dr. Quigley read a resolution from the Rhode Island Medical Society, which the delegates from that society will submit in San Francisco, requesting the A. M. A. to amend its action relative to certification of illness in cash sickness benefit plans, and to make a study of existing and proposed compulsory temporary disability compensation programs and report its findings to each state medical society before January, 1947.

Dr. Stahl moved that the Trustees adopt in principle the Rhode Island Medical Society resolutions and recommend that our delegates advocate them at the A. M. A. House of Delegates in July. Seconded by Dr. Coleman and unanimously carried. It was directed that a copy of the resolutions be sent to each of our A. M. A. Delegates.

Dr. Quigley reported that the Commission on Post-War Economic Welfare, in response to a joint resolution of this session of the Legislature, has made a study of cash sickness benefits, and recommends the setting up, in the Unemployment Compensation Commission, of a plan for cash sickness benefits to workers unemployed because of illness or disability, utilizing to the fullest extent existing voluntary plans and making it obligatory upon employers to establish such a plan with minimum benefits partly to compensate workers while disabled by sickness. It would be obligatory upon other employers to carry insurance to provide these benefits. The Commission recommends that it be a state *supervised* plan rather than a state *operated* plan.

3. The Washington Office of the A. M. A. informed Dr. Quigley that Senate 1318—the Pepper Bill—which would provide obstetric care to all women regardless of ability to pay and would provide medical care for all children up to 21 years of age, regardless of financial status, will be brought before the full Committee on Education and Labor of the Senate on June 22. Dr. Quigley plans to attend this hearing and present a prepared brief. The American Medical Association is going to send two representatives, though they were "advised" that speakers would not be needed.

4. In response to a request from Dr. Lewis for a definite recommendation to the Delegates from the Trustees relative to S. 2143, Dr. Stahl moved that the Trustees recommend to our Delegates that they advocate the principles of the plan proposed in the Taft-Smith-Ball Bill, S. 2143. Seconded and unanimously carried.

BOARD OF MEDICAL EXAMINERS

Upon motion by Dr. Stahl, seconded by Dr. Coleman and unanimously carried, the following recommendations for appointment to the Board of Medical Examiners for the term of Dr. Royal A. Schaaf, expiring July 6th, were directed to be sent to the Governor:

Royal A. Schaaf, Newark
Aldrich C. Crowe, Ocean City
Sigurd W. Johnsen, Passaic

Upon motion by Dr. Costello, seconded by Dr. Johnsen and unanimously carried, the following recommendations for appointment to the Board of Medical Examiners for the term of Dr. Samuel Barbash, expiring July 6th, were directed to be sent to the Governor:

Samuel Barbash, Atlantic City
Joseph G. Coleman, Hamburg
E. Zeh Hawkes, Newark

WELFARE COMMITTEE RECOMMENDATIONS

The recommendation that the Publication Committee grant such space in THE JOURNAL, as is required, to the Advisory Committee on Laboratory Medicine, for articles on new laboratory procedures, was approved upon motion by Dr. Schaaf, seconded and unanimously carried.

The other recommendations * were tabled by individual actions by the Board, and Dr. Hawkes moved that the tabled recommendations be sent to each member of the Board for study, and that they be placed on the agenda for the next meeting of the Trustees. Seconded by Dr. Costello and unanimously carried.

REAPPOINTMENT OF EMPLOYEES

Upon motion by Dr. Schaaf, seconded and unanimously carried, the following employees were reappointed for one year at existing sal-

* See pages 288-289 this issue.

aries, as approved by the House of Delegates on May 23, 1946:

Dr. Frederic J. Quigley, Executive Secretary, Subcommittee on Legislation, salary $5,000, plus existing expense arrangements.
Dr. Henry A. Davidson, Executive Secretary, Subcommittee on Public Relations, salary $1200, plus traveling expenses.
Dr. Henry A. Davidson, Editor, salary $2500, plus traveling expenses.
Mrs. Edith L. Madden, Acting Executive Officer, salary $1000.
Dr. Norman M. Scott, Executive Assistant, on full time loan to Medical Service Administration, salary $4000, plus $3500 additional salary paid through Medical Service Administration.

HEALTH AND SANITARY ASSOCIATION

Secretary Green read a communication from Dr. C. Byron Blaisdell acknowledging his appointment by the Trustees as a representative of The Medical Society of New Jersey on the General Council of the New Jersey Health and Sanitary Association, but suggesting that someone be appointed in his place in view of the fact that he is president of the association.

Dr. Costello moved that the matter be left in the hands of the chairman of the Board with power to act. Seconded and unanimously carried

MEDICAL SERVICE ADMINISTRATION

Secretary Green read a communication from Dr. Norman M. Scott, Medical Director of MSA and MSP, requesting the nomination of members of the Board of Governors of Medical Service Administration and the Board of Trustees of Medical-Surgical Plan, and requesting approval of the continuation of the Farm Security Medical Plan for 1946-47 and requesting that the County Societies urge the continued cooperation of their members at the present fees of $1.50 per office call and $2.50 per house call for this group, regardless of minimum fees which may have been approved as applicable to other groups.

Dr. Costello moved that the requests of Medical Service Administration relative to the Farm Security Medical Plan be concurred in, and that the present members of the Board of Governors of MSA and the Board of Trustees of MSP be renominated. Seconded and unanimously carried.

TRUSTEE MINUTES TO COUNTY SOCIETIES

In order that the County Societies may be better informed of the activities of the Board of Trustees, and have opportunity to make suggestions and recommendations to the Board, Dr. Hawkes moved that a copy of the minutes of each meeting of the Board of Trustees, in the same form in which they are forwarded to the members of the Board, be sent to the Secretary of each County Medical Society as soon after the meeting as practicable. Seconded and unanimously carried.

ANNUAL MEETING

Mrs. Madden reported that the total receipts from the Annual Meeting were $4,434.00, expenditures $4,221.10, showing a net profit of $212.90.

PHYSICIANS' FORUM

Dr. Schaaf reported that the Physicians Forum is trying to establish a New Jersey Chapter. The Essex County Medical Society requested that this be brought to the attention of the Trustees with the suggestion that the membership be informed that the policies and principles of the Physicians Forum are in direct opposition to the policies and principles of The Medical Society of New Jersey.

Dr. Schaaf moved that a circular letter be sent to the membership informing them of the character of the Physicians Forum and stating that we do not favor it as an organization. Seconded by Dr. Stahl and unanimously carried.

Dr. Lance moved that the Chairman of the Board of Trustees be empowered to appoint two or more members to draft a letter to the membership calling attention to the acceptability of the policies of the National Physicians Committee and warning them against other groups. Seconded and unanimously carried.

Chairman Crowe appointed Drs. Schaaf, Costello and Londrigan to draft such a letter.

MEDICAL-SURGICAL PLAN

Dr. Stahl urged that something be done to increase the enrollment in Medical-Surgical Plan more rapidly. Following discussion, Dr. Schaaf, speaking as a member of the Board of Trustes of Medical-Surgical Plan, recommended that the Trustees authorize Medical-Surgical Plan Board of Trustees to raise the income limit for subscribers to $2500 for a single person, 3000 for a man and wife and $4000 for a family with children, with a view to increasing the sale of contracts.

Dr. Costello moved that the matter be tabled and that the members of the Trustees be circularized concerning this recommendation, and that it be placed on the agenda for the next meeting of the Board. Seconded by Dr. Lance and unanimously carried.

The meeting was adjourned upon motion at 4:30 p. m.

WELFARE COMMITTEE — JUNE 16, 1946

Attendance:

Hilton S. Read, Chairman
Edward H. Guion (Atlantic)
George Heller (Bergen)
Luke A. Milligan
H. Wesley Jack (Camden)
Charles Cunningham, Jr. (Cumberland)
Albert B. Kump
J. Wallace Hurff (Essex)
Harrold A. Murray
H. Roy Van Ness
Wendell J. Burkett (Gloucester)
Chester I. Ulmer
Reeve L. Ballinger (Hudson)
Vincent P. Butler
Berthold S. Pollak
Hugh H. Tyndall
Philip W. Baker (Hunterdon)
Barclay S. Fuhrmann
Samuel Blaugrund (Mercer)
Ralph J. Faulkingham (Middlesex)
John H. Rowland
Granville L. Jones (Monmouth)
Stanley Nichols
George B. Emory, Jr. (Morris)
George L. Nicoll
Adolph Towbin (Ocean)
Homer H. Cherry (Passaic)
H. Hale Hollingsworth
Joseph R. Jehl
Frank L. Perry (Salem)
Lewis C. Fritts (Somerset)
Thomas J. Walsh (Union)
William H. Varney (Warren)
Henry A. Davidson (Public Relations)
John J. Debus (Pharmaceutical)
William H. MacDonald (Department of Health
Frederic J. Quigley (Legislation)
Alfred Stahl (Secretary of the Society)
Guests
Clyde M. Fish
Christian P. Segard
George W. Fithian
John A. Smith
Royal A. Schaaf
Harold F. Tidwell
Asher Yaguda
William K. Harryman
Watson B. Morris
Jerome G. Kaufman
Joseph G. Coleman
Norman M. Scott
Abraham E. Jaffin
Henry C. Barkhorn
W. James Marquis

Chairman Read called this organization meeting to order at 1 p. m.

COMMITTEE ON LEGISLATION

Dr. Pollak reported that the Legislative Committee had reappointed Dr. Frederic J. Quigley as Executive Secretary.

Upon motion, seconded and unanimously carried, the reappointment of Dr. Quigley as Executive Secretary of the Legislative Committee was confirmed.

Dr. Pollak then read the report of the Legislative Committee, reprinted on page 291 of The Journal.

Upon motion, seconded and unanimously carried, the report was adopted.

In addition to the formal report, Dr. Quigley made a supplementary informal statement, abstracted on page 292 of this Journal.

On motion made, seconded and carried, the Welfare Committee voted to express disapproval of bill S. 1318 now pending in the United States Senate.* It was ordered that this expression of opposition be forwarded to our Board of Trustees and to U. S. Senator Smith.

PUBLIC RELATIONS COMMITTEE

In the absence of the Chairman, Dr. Sica, the report of the 1946-1947 organization meeting of the Public Relations Committee was read by that Committee's Executive Secretary, and is reprinted on page 290 of this Journal.

Upon motion, the report of the Public Relations Committee was adopted and its recommendations accepted. The Chair took this opportunity to express the Welfare Committee's thanks to Dr. Henry C. Barkhorn, chairman of the Publication Committee, for maintaining the Journal's high standards during the difficult war years.

PUBLIC HEALTH

Dr. Blaugrund, newly appointed chairman of the Public Health Committee, reported (in abstract) as follows:

"It is well to state at the very outset that I am an embryo in this committee. I am not rendering a formal report today because our session was an organization meeting in which no specific recommendations were made for enactment. It is important, however, to give you a cross-section of what happened in discussion this morning. Basically, we found fault with ourselves. This public health program is one in which doctors must work in conjunction with organized agencies interested

* See page 292, this Journal.

in various phases of public health, some governmental, some lay and some political. We find this to be a fact—and I say it must be a fact because thirteen men speaking independently this morning came to the same conclusion—that the doctor sits on many public health committees in his community, but he rarely functions. His name on those committees is window dressing. They use doctors' names—and they pick out prominent physicians—but frequently the doctor never attends a meeting. Usually somebody outside of the profession is arranging these public health programs. The thirteen gentlemen who met this morning are insistent that the medical profession not only show interest, but assume leadership. For example, there is Dr. Tidwell's report on 'What Constitutes a School Health Program'. That report was made before the Academy of Pediatrics last year and adopted. I don't know what happened to it—it is probably still on file. Dr. Tidwell made a very fine, exhaustive study, with concrete and practical recommendations, which you will get in the fall.

"I promised the chairmen of the advisory committees that I would get their recommendations in writing; I would follow them through to the next step, which is the Welfare Committee, for its action; and then the next step, the Board of Trustees, for its action. I will see that the various chairmen who give of their time and effort get action for that work.

"I have never seen in any newspaper a report that any state medical society had a preventive measure for poliomyelitis. I find all this from government agencies. I see news releases from the National Foundation for Infantile Paralysis. They do a grand job—they collect vast sums. Recently they released a moving picture on poliomyelitis. It shows what the Foundation does; but there was nothing about the part the doctor plays in the treatment of this disease.

"This committee has to work in harmony with the Public Relations Committee and see that, through the Public Relations Committee, we are known in the newspapers for our participation. After all, none of these lay groups can function without the doctor. We are not aggressive enough. Perhaps our men are too busy in their offices.

"Now that the war is over we must assume responsibility; in fact, we must take leadership because it belongs to us. Lay groups and government agencies are willing to cooperate and they are anxious for us to take the medical leadership.

"We declared here in Trenton that May 13th would begin Public Health Week, sponsored by the Mercer County Medical Society. We got audiences through the Community Chest. We did not ask for volunteer speakers from our Medical Society. We had contact with our Speakers' Bureau, which we took from our own membership, and addressed organizations like Kiwanis, Rotary, Lions Clubs and so forth. We had radio time every day and with proper contacts with our local newspaper we had first-page publicity every day, plus three editorials and letters written to the editor. So you see, there are ways of actually showing leadership. It would not be amiss for the State Medical Society itself to declare one 'Public Health Week, sponsored by The Medical Society of New Jersey'. Let us take the medical leadership and present subjects to the public as they should be presented. They will welcome it."

MEDICAL PRACTICE COMMITTEE

Dr. Ballinger offered for action the following recommendations of the Subcommittee on Medical Practice:

1. That a section on clinical pathology be created within The Medical Society of New Jersey.
2. That THE JOURNAL each month give space to articles on laboratory procedures.
3. That the Counsel of our Society be asked for a reinterpretation of section 45:9-18 of the Medical Practice Act as it applies to non-physicians practicing laboratory medicine.
4. That the Welfare Committee endorse the proposition that the Director of Laboratories of the State Deparment of Health be an M.D. specializing in laboratory medicine.
5. That instead of approving laboratories, as such, the Board of Health approve the directors of laboratories, and that such directors be M.D.'s specializing in clinical pathology.
6. That the 1940 report of the Advisory Committee on Auxiliary Medical Services (printed in the May 1940 JOURNAL) be republished or that copies of it be sent to each member.
7. That funds be provided to the State Board of Medical Examiners either through an annual registration fee or by means of a donation from The Medical Society, for the purpose of assisting them in the enforcement of the medical practice act.

Each suggestion resulted in considerable discussion which is summarized below.

1. *That a section on Clinical Pathology be created within The Medical Society of New Jersey.*

Dr. Jaffin: The breaking-up of our Annual Meeting into too many sections is to be viewed with regret. I find that I cannot divide myself up when I go to Atlantic City, to attend all the sections in which I am now interested. Here you propose to create still another section, on a subject in which many of us are interested, and we are going to be torn between attendance at this new section and attendance at several of the others.

Dr. Murray: Dr. Jaffin is correct. Not only for the reason he gives but also because we have so much difficulty finding space for all these sections. Clinical pathology could be included in the Section on Medicine; and part of their program might be set aside for this purpose.

Dr. Asher Yaguda: The reason for this suggestion is not especially a desire to have a separate section meeting. This year the pathologists met at the Atlantic City Hospital where the New Jersey Society of Clinical Pathologists held its session. Our Society of Pathologists now numbers 60 members, and we are increasing rapidly, and would like, as a group, to be affiliated with the State Medical Society. We do not insist on a separate section program; we will be glad to have a place in the Section on Medicine.

The question was put to a vote and carried.

2. *That the Publication Committee be requested to give space each month to an article on new laboratory procedures, with a discussion of their value, limitations and interpretations, in order to call attention of the doctors to the advances in the field of clinical pathology.*

At the suggestion of Dr. Barkhorn the words "as is required" were substituted for "each month". It was regularly moved, seconded and unanimously carried that recommendation 2 be adopted as amended.

3. *That the counsel of the State Medical Society be asked for a reinterpretation of Section 45:9-18 of the medical practice act as to its applicability to persons practicing laboratory medicine without a medical degree.*

At the suggestion of Dr. Quigley, recommendation 3 was referred to the Legislative Committee, which will take the matter up with counsel and report the result at the next meeting of the Welfare Committee.

4. *That the Welfare Committee be asked to endorse the proposition that the Director of Laboratories of the State Board of Health should hold a degree of doctor of medicine and be a specialist in the practice of laboratory medicine.*

Dr. Yaguda: We have information that a recommendation of this type would be welcomed by the new administration of the State Department of Health, after its reorganization. A recommendation of this sort should come from the proper source to receive adequate attention, and for that reason it has been presented to the Welfare Committee.

Dr. Segard: There are many fine men teaching in hospitals and medical schools today who do not have medical degrees, and I would hate very much to see such a motion passed by this body. We must recognize there are many men in the field of biology, etc., who are not graduates in medicine, but do a splendid job in teaching such subjects.

Dr. Yaguda: The practice of clinical pathology has been recognized by resolution by the A. M. A. and by the State Society as a specialty in the practice of medicine. The men who are teaching bacteriology, physiology, etc., in medical schools are not *practicing* medicine within the meaning of the Medical Practice Act. What we are trying to do is to prevent unqualified persons from practicing in the state.

Upon motion, regularly seconded and carried, recommendation 4 was adopted:

5. *That the State Board of Health stop approving laboratories as such, but rather approve the director of a laboratory, who shall of necessity be a doctor of medicine specializing in clinical pathology.*

Mr. MacDonald: I know the Department is considering some possible change in its method of approving laboratories. Up to this time it has been approving only laboratories doing examinations for the Health Department.

Upon motion, recommendation 5 was amended and adopted in the following form:

"That the State Board of Health be advised that The Medical Society does not approve the practice of approving laboratories as such, but recommends rather, the approval of the director of a laboratory, who shall of necessity be a doctor of medicine specializing in clinical pathology."

6. *That the report of the Advisory Committee on Auxiliary Medical Services, printed in the May 1940* JOURNAL, *pertaining to the economic relationship between specialities of radiology, laboratory medicine, physical medicine and anesthesiology, be either republished in the* JOURNAL *or that a copy be sent to each physician in New Jersey.*

It was regularly moved, seconded and carried that the 1940 report be abstracted and published in synopsis form, if approved by the Trustees.

7. *That adequate funds be provided to the State Board of Medical Examiners either through an annual registration fee or through the treasury of The Medical Society of New Jersey, for the proper enforcement of the Medical Practice Act.*

Dr. Burkett: As president of the State Board of Medical Examiners, let me say that we have more money in the treasury than we have ever had. Unfortunately, at the end of the fiscal year—June 30, 1946—we have to return the balance to the State Treasury. We do not need any funds. We do need Annual Registration, since now we have no way of knowing who moves in or out of the state. The only way we have of knowing that some physician has died is when we see it in a record and it is brought before the Secretary of the Board. I hope this committee will heartily endorse Annual Registration. It is quite true that a year from now we might be depleted. I might explain that the reason the State Board is in such a good position is because of the number of men who have come into the state by endorsement. I do not believe there will be such an influx of physicians every year. The war has been a factor. Some men have come as far as from the midwest. We have received a great deal of revenue from that source. I would like to see the word "fund" deleted from your recommendation.

Dr. Ballinger: In Atlantic City last month I spoke to another member of the State Board of Medical Examiners, reciting a case in Newark of a man who has practiced without a license for two years. It was only last month that the State Board caught up with him. The member with whom I talked said, "If we had enough money we could prosecute." For every case of malpractice the cry has been the same—"If we only had enough money to prosecute these cases," and this is the first time that I have been told it was not the funds holding back prosecution of these cases.

Dr. Yaguda: That impression is state-wide. The question came up at the annual meeting of the New

Jersey Society of Clinical Pathologists and the suggestion was even made that the pathologists of New Jersey provide a fund which they would support the State Board in the prosecution of these cases.

Dr. Burkett: The State Board of Medical Examiners does not prosecute these cases. A case which is prosecuted must come through the courts. After that case hase been prosecuted the matter comes before the State Board and we act on his license, as to the penalty he has received, whether it be a suspension or a revocation of his license. When it comes to investigating a case, we spend money. The primary reason that more cases are not prosecuted is that we cannot get investigators. It takes two individuals to investigate every case. Every other profession—dentists, nurses, optometrists, and pharmacists—has Annual Registration.

Upon motion, regularly moved and carried, recommendation 7 was adopted by the Welfare Committee.

Upon motion, regularly moved and carried, the report of the Medical Practice Committee as a whole was adopted.

CARE OF VETERANS

Dr. Scott presented the report on the Veterans Care Plan, which is reprinted on page 280 of this JOURNAL . In that connection, Dr. Pollak reported that he had attended a meeting of the National Tuberculosis Association in Buffalo recently and that General Hawley, at that meeting, described the "New Jersey plan" as the most satisfactory one he had seen. He stated that he had advised Kansas to copy the New Jersey plan.

WOMAN'S AUXILIARY

Dr. Dodd, chairman of the Advisory Committee to the Woman's Auxiliary, reported as follows:

"The Auxiliary is starting a new year of activities. The woman power of the state represents a tremendous force which, properly unified and guided, can be of material help to the doctors and to the various committees of The Medical Society. In the past, the tendency has been to call on the women whenever the men got into trouble. I appeal to you now, when your plans for the year are in a formative state, to remember the Woman's Auxiliary. Ask yourself what part the women can play in the activities of your committee, call on them, forward your plans and requests either through Mrs. Wandell or through your county advisory committee; or send them directly to me. You will get more help if you incorporate their work in your plans at the beginning of the year."

The Welfare Committee adjourned at 2:30 p. m.

PUBLIC RELATIONS SUBCOMMITTEE

The Public Relations Committee held its 1946 organization meeting on June 16. The general program successfully pursued last year (radio talks, newspaper columns, and information service) was approved for continuance this year. The problem of procuring medical speakers on administrative and economic problems was discussed and the committee voted to establish a Subcommittee on Speakers * to be made up for three members from each Councillor District. These members would evaluate the personnel of their respective districts with a view towards building up in each area a panel of speakers willing and able to take to the platform on medical administrative and economic problems. This would enable the Society to meet its commitments to the public for furnishing such speakers. The subcommittee would also be authorized to establish at intervals a seminar or training program where the necessary factual data could be supplied to speakers.

The committee recommended that more and better publicity be given locally to county society meetings and to that end asks the Welfare Committee * to instruct reporters in each county society to prepare newspaper releases after each meeting. The Public Relations Committee instructed its Executive Secretary to convene a meeting of the reporters if necessary for the purpose of exchanging ideas as to the best methods for preparing and distributing such releases. The committee also recommends the maintenance in the Trenton Office of a list of members classed by specialty * and locality so that requests for the public or from official bodies for the names of specialists might be met. It was suggested that each member of the Society indicate how he wants to be listed with reference to specialty and that these names and listings be collected separately by the secretary of each county society and assembled in a central file in Trenton.

* These recommendations were all subsequently approved by the Welfare Committee.

SUBCOMMITTEE ON LEGISLATION

At its 1946-1947 reorganization meeting on June 16, the Subcommittee reelected Dr. Frederic J. Quigley as Executive Secretary. There was then discussion of plans for strengthening and integrating our legislative efforts, especially as to public relations. This year, in addition to Legislative Bulletins being forwarded to County Society Officers and Legislative Keymen, we issued Legislative News Letters, which included all bills that had any public health implication, and also other bills which we felt might be of interest to the profession. We would be glad to receive reactions to continuing the issuance of the Legislative News Letters, and any suggestions to keep the membership better informed. These Bulletins and News Letters do go, at present, to all County Society Officers and Keymen. If any County Societies which have Legislative Committees would like this material forwarded to the members of these committees we would be glad to do so.

More and more we are convinced of two things with respect to the legislative work of the Society:

1. That it represents at the moment—and shall continue to for a long time to come, so far as we can see—the most important single Society effort.

2. That what success or lack of success we may have in our legislative efforts is dependent in no small degree upon what is done or not done by the other subcommittees of the Welfare Committee, and upon how well the work of the other subcommittees is carried out. Constructive interest in public health and sound plans of medical practice, to meet the changed conditions, and how well this is told to the public through the activities of the Subcommittee on Public Relations, will determine in large measure what legislation we will have to meet, and how successful we shall be in meeting it. We believe that the preventive aspects of legislative work are the most important and fruitful.

These ideas are the reason, if not the justification, for this subcommittee's comments upon the following:

ENROLLMENT IN MEDICAL-SURGICAL PLAN

In the annual report of Dr. Scott, Medical Director of Medical-Surgical Plan, to the House of Delegates, he stated, "It must increase its enrollment more rapidly if it is to fill the needs of New Jersey." With this statement we heartily agree, and, looking at it from the legislative angle, if our state and all other states do not markedly increase enrollment in medical service plans we have not much of an argument to combat the proponents of compulsory sickness insurance. It is not the function of this subcommittee to go into the reasons for the slow enrollment in the Medical-Surgical Plan of New Jersey, as compared with other state plans which started at a much later date; but we do believe it is our function to call to the attention of the Welfare Committee the need for increased efforts for a faster spread of coverage.

WORKMEN'S COMPENSATION ACT

Every year, for the past four years, there have been introduced in the State Legislature from 15 to 25 bills proposing to amend the Workmen's Compensation Act. It is impossible for this committee to know what amendments proposed are desirable, and we doubt that the Committee on Workmen's Compensation, during the short period of the Legislative Session, would have time adequately to analyze these bills and inform the Legislative Committee as to what bills should be supported and opposed. We would suggest that the Committee on Workmen's Compensation, between now and the opening of the Legislature, study the medical aspects of the act and recommend, in a broad way, what changes are desired.

CASH SICKNESS BENEFITS

In the Report of the Committee on Legislation, presented this year, we mentioned the fact that pursuant to a joint resolution of the State Legislature the Commission on Post-War Economic Welfare held hearings on the proposal to establish a system of cash sickness benefits. The Commission, in brief, recommended that instead of the state *operating* a system of cash sickness benefits for workers who were unemployed because of sickness or disability, the state *supervise* a plan for the payment of cash sickness benefits. Bills to accomplish this purpose were introduced in the closing days of the last session of the Legislature, and most likely will be reintroduced at the coming session. The plan proposed would make it obligatory upon the part of all employers to establish a plan with minimum benefits partly to compensate workers while disabled by sickness. This plan would encourage the utilization and extension of presently existing plans set up by employers or jointly by employers and employees. And employers who do not establish voluntary plans would be obliged to carry insurance to provide these benefits. In view of the fact that provision for cash sickness benefits was one of the recommendations made by President Truman in his message to the Congress on health last May, this subject becomes of paramount importance. The Wagner-Murray-Dingell Bill would not permit the establishment and operation of state plans, but would provide cash

sickness benefits on a national plane. If our state and a few others quickly enact legislation to provide for these benefits, especially if it is of a pattern similar to that recommended by the Commission on Post-War Economic Welfare, it would seem that there would then be solid argument against such a plan by the national government. Inasmuch as the House of Delegates of the A. M. A. is on record in support of the principle of cash sickness benefits it would seem highly desirable that the plan proposed and just described should have the support of the medical profession of this state.

TAFT-SMITH-BALL BILL—S. 2143

Reference to this measure was made in the annual report of this committee and the principle of state aid to provide for adequate medical care for persons with low incomes was endorsed. As presently written, we see administrative difficulties in the bill. We understand that the sponsors of the measure do not feel that it is a perfect instrument and are quite willing, we are informed, to sit down, in the fall, with representatives of organized medicine in an endeavor to perfect the bill so as to accomplish the purposes intended.

We suggest that every member of the Welfare Committee write to Senator H. Alexander Smith (Senate Office Building, Washington 25, D. C.) and request a copy of S-2143. The mere request for a copy is, we believe, a good public relations gesture.

B. S. Pollak, M.D., Chairman.

SUPPLEMENTARY REPORT

Dr. Quigley gave orally a supplement to the above report, which is here published in abstract:

"I have just been informed that Senator Pepper has been successful in having S. 1318 scheduled to be brought up for consideration before the full Committee on Education and Labor of the U. S. Senate. This is an abrupt and unexpected move. The American Medical Association has been advised that it would not be necessary to have representatives of the Association appear in opposition; nevertheless it was the intention of the A. M. A. to have two representatives there; one of them will be Dr. Howard, past president of the Connecticut State Medical Society. Members are reminded that Senator H. Alexander Smith of our State is a member of the Committee on Education and Labor. It is most important and necessary that we prepare a statement in opposition to this bill. S. 1318 was introduced by Senator Pepper and five other senators, and would, if enacted, afford obstetric care to every woman in the United States regardless of her financial status, and medical care to every child in the United States up to 21 years of age regardless of financial status. At the first meeting of the Welfare Committee last fall, one of the speakers, Mr. J. W. Holloway, Jr. (director of the Bureau of Legal Medicine and Legislation of the A. M. A.), mentioned that in his opinion S. 1318 was more immediately dangerous than any other bill pending before Congress because of the sentimental appeal it made as it was ostensibly in favor of women and children.

"The bill was discussed by our Legislative Committee on June 16 and it was their feeling that it would be desirable that I go to Washington for the hearing on June 22, so that at least Senator Smith would know that I was there.

"It was the committee's thought that it would be a good idea for this Welfare Committee again to go on record as opposing the Pepper bill, not with the intention of disapproving maternal and child care, but because it would provide for these services regardless of a person's financial status. It is also the committee's desire that, if this meets with the approval of the Welfare Committee, the action taken should be brought to the Board of Trustees so that they may also take appropriate action."

(Dr. Ulmer moved that the Welfare Committee go on record as opposed to S. 1318 and that that opposition be relayed to the Board of Trustees and to Senator Smith. Regularly seconded and unanimously carried.)

COURSE IN NEUROPSYCHIATRY

An intensive course in neuropsychiatry will be available to New Jersey physicians this fall. Sponsored by the N. J. Neuropsychiatric Association, the course begins September 6 and terminates December 9. Classes will meet every Monday, Wednesday and Friday from 7 to 9 p. m., in Newark. Fee for the complete course is $100. Some of the partial courses may be taken separately. For application form or further information write to: Dr. Henry A. Davidson, 533 Mt. Prospect Avenue, Newark 4. The course is open to physicians only.

THE DOCTOR AND THE CANCER PROGRAM

The New Jersey Division of the American Cancer Society, under the vigorous leadership of its president, Mr. George E. Stringfellow, is launching an energetic program this year which calls for the cooperation of every doctor in New Jersey. The nature of this project is indicated in the following exchange of letters between Mr. Stringfellow and Dr. Keir, chairman of the Cancer Committee of The Medical Society of New Jersey:

From: Mr. Stringfellow
To: Dr. Keir
Dated: May 20, 1946

Dear Doctor Keir:

Last year the people of New Jersey contributed nearly seven times as much money as ever before to finance the Cancer Society's program of research, education, and service. This year, they have almost doubled their contributions of last year. Our experience in raising cancer funds in this state convinces me that our citizens will give us whatever money we can use intelligently for the control of the disease.

During the coming year, we will have nearly $400,000 to spent in New Jersey for education, for detection and diagnosis, and for the treatment and care of cancer patients. To make possible the expenditure of this money in ways that will accomplish our objective effectively, we need the cooperation of public-spirited physicians throughout the state in formulating plans and projects.

A large proportion of our money will be spent on local projects as developed by county chapters. All local projects and programs that involve questions of detection, diagnosis, treatment and care will originate with or be approved by the local medical societies. All state projects and programs involving medical procedures, practices, and problems will have the approval of the cancer committee of The Medical Society of New Jersey.

It is the responsibility of the doctors to advise how, where, and for what facilities, programs and services money shall be spent. It is the responsibility of the laymen to raise the money and to administer the funds in accordance with sound business practices.

In order that we may undertake the spending of the money raised this year, and the bulk of the money raised last year, we must have local chapters, properly organized and officered, to plan the spending. These chapters are to be the foundation of the society. They will elect their directors and officers and the members of the state board of directors, which in turn elects the national board of directors. In order that the policies of the society may be uniform, the state division operates under a charter granted by the national society, annually renewable and revocable for cause. Local chapters will be chartered in the same manner by the state division.

The chapter's board of directors will be divided between medical and lay members, as will be the membership of the state board. The Cancer Committee of the local medical society will be the Medical Committee of the local chapter. The Cancer Committee of the state medical society is the Medical Committee of the State Division. The chairman of the Executive Committee of the State Division is a physician. The chairman of the Executive Committee of each local chapter will be a physician, and also chairman of the Service Committee. Laymen hold the business offices of the State Division and will be chapter presidents, secretaries, treasurers, and members of committees on education, finance, fund-raising, and publicity.

The Advisory Cancer Committee of the State Medical Society has cooperated in formulating the plans of the State Division, and is now, as you know, analyzing a survey of all hospitals and clinics in the state, to determine what we have and what we need.

It is my hope that the more than five thousand physicians in our state and the civic-minded laymen will pool their technical knowledge, financial resources and business ability to the end that suffering and death from cancer may be promptly minimized and the cause and control of this disease be discovered at an early date.

Sincerely yours,
GEORGE E. STRINGFELLOW, President,
New Jersey Division,
American Cancer Society.

From: Dr. Keir
To: Mr. Stringfellow
Dated: May 21, 1946

Dear Mr. Stringfellow:

The Advisory Cancer Committee of the New Jersey Medical Society congratulates you and your colleagues on the successful termination of the 1946 campaign for funds. We are deeply impressed with the efficient methods you are introducing into the business administration of the American Cancer Society.

You and your advisers have set in motion the machinery for a unified state cancer program involving governmental, professional and welfare agencies with proper allocation of the respective responsibilities for service to the cancer patient. The laymen accepting business problems; the physicians assigned to the problem of diagnosis and treatment; and the agents of government and welfare societies directed to the many other problems in cancer work. You aimed at a high mark for the campaign fund and then attained it. Now, your aim is at a better organizational setup, as outlined in your letter, and should be equally successful. It meets the concensus of this committee.

The task of developing a yearly cancer program and setting up of a budget, at the state level, is endorsed by this committee on behalf of the State Medical Society. We shall attempt to discharge this service in the same good faith with which you and your worthy helpers have collected the funds. I trust that you are mindful that cancer is but one of the many chronic diseases which calls upon the physician's time and energy.

We are all aware that, on the state level, the responsibility is shared by the Board of Health, and Institutions and Agencies who have in the past cooperated so well in the cancer program. This committee is indebted to Dr. L. S. Snegeriff and his associates from the Board of Health, and Dr. Emil Frankel from Institutions and Agencies for excellent service in conducting the survey of cancer facilities in New Jersey.

At the county level, this committee recommends that every County Medical Society immediately ap-

point an active cancer committee from the practitioners interested in cancer. We feel certain that every County Cancer Committee will develop a program, set up a budget, and secure the approval of the County Medical Society so that the New Jersey Division of the American Cancer Society can finance the local project.

It is our understanding that the chairman of each county executive committee will be a physician and that each county chapters elects one physician and one lay delegate to serve on the State Board of Directors, which we understand is the governing body of the organization.

We are proud to learn that you have been appointed a member of the National Executive Committee which places this state in a position for good representation at National Headquarters.

This committee assures you that every physician in New Jersey, active in organized medicine, will be informed of the proposed plan. Your letter and this communication will appear in The Journal of The Medical Society of New Jersey.

We are confident that, as individuals and as members of county Medical Societies, the local physicians will avail themselves of this opportunity to demonstrate that philanthropy, medicine, and local government can work together on the cancer problem without the aid or assistance of the Wagner-Murray-Dingell Senate Bill S-1606.

With kindest regards and best wishes for your continued success, we are,

Sincerely yours,
Floyd E. Keir, M.D., Chairman,
Advisory Cancer Committee of
Medical Society of New Jersey.
Committee Members:
William O. Wuester, M.D.,
Vice-Chairman
Otto R. Holters, M.D.
Harry R. Brindle, M.D.
Joseph H. Kler, M.D.
Joseph I. Echikson, M.D.
Thomas B. Lee, M.D.

NUTRITION IN EVERYDAY PRACTICE

S. William Kalb, M.D., Newark, N. J.
Chairman Nutrition Committee

1. *Is insulin beneficial for the treatment of underweight patients?*

   Not always. The appetite will be increased with the use of insulin only in patients who have a flat glucose tolerance curve.

2. *Why do so many infants fail to respond to vitamin A therapy?*

   Vitamin E prevents oxidation and loss of vitamin A; therefore, these should be used together when response is poor to vitamin A.

3. *Is it necessary to give orange juice to infants early?*

   Yes. They should get it from the first week because the amino-acids in the milk do not remain long with them. The vitamin C in the orange juice is important in the utilization of amino acids.

4. *Two patients recently developed kidney stones. One had a fracture of the hip and was convalescing when the attack occurred; the other was convalescing from an osteotomy. Was there anything lacking in the diets to cause the attacks?*

   Urinary lithiasis is a frequent complication of skeletal injury. Calcium excretion in the urine rises approximately a month after injury and reaches its peak at the height of the protein breakdown process. Milk in the diet is preferable to calcium lactate or other calcium preparations. An increase in dietary calcium and dietary phosphorus found in cow's milk is of benefit as a prophylaxis against lithiasis.

5. *Are vitamins of value in hyperemesis gravidarum?*

   Yes. Vomiting of pregnancy produces a hypovitaminosis. It is necessary to administer the basic formula with an added amount of vitamin C.

6. *Should minerals be added to a formula when vitamins are prescribed?*

   Not unless there is reason to suspect a mineral deficiency. Enough of these elements are usually supplied, even in a very poor diet.

7. *What is meant by nutritive failure?*

   If, in the past, you've made a diagnosis of gastric neuroses, asthenia, or indigestion, from now on call it nutritive failure and treat it as such. Some psychoneuroses will also fall into this group.

8. *Should vitamins be given to patients on obesity diets?*

   Yes; and also to patients on restricted diets for gastric ulcer, gall-bladder disease, hypertension, kidney disease, etc.

EXPRESSION OF THANKS TO LOCAL P & A COMMITTEES

The Secretary has received a letter from the Directing Board of Procurement and Assignment Service thanking the Society and its agencies for "their patient and timeless devotion" to their important and difficult task. The text of the letter follows and is particularly called to the attention of the State and County Consultants and of the various committees who so faithfully participated in this work.

Dear Dr. Stahl:

For practical purposes the functions of the Procurement and Assignment Service have been terminated and the activities of the several State offices brought to a close. The success of the program in meeting the needs of the armed forces without sacrificing the civilian population may be attributed directly to the patient and timeless devotion of many State Committees and countless local advisers. Many of these committeemen and advisers are unknown to the Directing Board, except through the results of their efforts ,and it would obviously not be practicable to undertake to communicate with them.

In a recent letter to each State Chairman, I asked that the appreciation of the Directing Board be conveyed to all the State and local representatives whose full cooperation was essential to the ultimate achievement. The Directing Board, at its final meeting on May 17, 1946, resolved that the untiring efforts, kind tolerance, and successful accomplishment of these State Committee members and local advisers be commended to the appropriate professional State Society for suitable recognition by the Society.

I hope you will draw this recommendation to the attention of your Society, and that they will be disposed to afford some such recognition.

Sincerely yours,

FRANK H. LAHEY, M.D.,
Chairman, Directing Board,
Procurement and Assignment Service.

SUPPLEMENTARY LIST OF MEMBERS NO. 3

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

Abbato, Charles C., 32 Main st., Lodi (2)
Abraham, Albert, 15 Altamont court, Morrist'n (14)
Alcamo, John H., 321 S. 9th st., Newark (7)
Aronoff, Solomon, 4000 Bergenline av., UnionCity(9)
Barishaw, Samuel B., 25 Bentley av., Jersey City (9)
Bergmeyer, Josef T., 6500 Palisade av.,W.NewY'k(9)
Bitten, Robert M., 33 Romaine av., Jersey City (9)
Cappiello, William A., 352 7th av., Newark (7)
Connell, John N., 26 Carlton av., Jersey City (9)
Cook, Homer E., E. Cliff st., Somerville (18)
Crissey, Eleanor, 921 Bergen av., Jersey City (9)
Dailey, Jeremiah A., 57 Madison av., Madison (14)
DeFilippis, Ralph L., 228 Tremont av., Orange (7)
Deibert, Kirk R., 1st Na. Bk. Bldg.,H'ntingt'n,W.Va.
Della Fara, Lucian F., 206 1st av., Newark (7)
Denig, Ralph, 370 State st., Hackensack (2)
Dershewitz, Irving, 835 Montgomery st., Jer C'y (9)
DeSevo, Gerard E., 108 Fairview av., Jersey City (9)
Duckett, Warren J., 21 Carlton av., Jersey City (9)
Finkelstein, Max, 3258 Blvd., Jersey City (9)
Fliegel, Hilda C., 309 Baldwin av., Jersey City (9)
Fortunato, Joseph F., 224 Van Buren st., Newark(7)
Franklin, Sidney I., U.S.P.H.S.
Freeman, Joseph, 146 W. 32nd st., Bayonne (9)
Gianni, Angelo R., 37 Main st., Netcong (14)
Giglio, Louis A., 182 Park av., Paterson (16)
Halpern, Sophia L., 1311 Palisade av., Union City (9)
Hershey, Harry, 921 Bergen av., Jersey City (9)
Higgins, Thomas F., 224 Monmouth rd., Elizab'h(20)
Hollinger, Chauncey O., 253 Harrison av., Jer.C'y(9)
Hornick, Emil E., 307 Spruce st., Boonton (14)
Kanning, Frederick, 57 W. Allend'le av.,Allendale(2)
Keitlen, Philip B., 305 Academy st., Jersey City (9)
Keller, Rudolph J., 821 Garden st., Hoboken (9)
Kent, Donald F., 396 Main st., Chatham (14)
Krug, Alfred J., 1460 Clinton av., Irvington (7)
Largay, Arthur O., 937 Avenue C, Bayonne (9)
Lease, Henry J., III, 74th st., N. Bergen (9)
Leibovitz, Altan C., 261 Lexington av., Passaic (16)
Levendusky, Daniel E., 20 W.Main st.,Rockaway(14)
MacDonald, John J., 348 Ogden av., Jersey City (9)
Mandell, Sidney N., 313 Monastery pl., Union City(9)
Mangelsdorff, Arthur F., Martinsville (18)
Mango, Concetta G., 435 79th st., N. Bergen (9)
Menden, Julian, 45 E. Blackwell st., Dover (14)
Mullin, Raymond J., 76 Shanley av., Newark (7)
Murphy, Leo J., 1814 West st., Union City (9)
Oatman, Jack G., N.J. StateHosp.,Greystone Pk.(14)
Padney, Edward V., 452 Jersey av., Jersey City (9)
Perlmutter, Irving K., 74 S. Munn av., E. Orange(7)
Provenzano, Samuel, 310 S. 10th st., Newark (7)
Rabinowitz, Jacob H., 755 Clinton av., Newark (7)
Ravitz, Israel, 4 Newman av., Verona (7)
Read, Donald B., 105 Hudson st., Jersey City (9)
Robbins, Eugene, 909 Broad st., Newark (7)
Ruvane, Joseph J., 2787 Boulevard, Jersey City (9)
Schapiro, Morris, 83 W. 33rd st., Bayonne (9)
Schiffmann, Samuel, 107 Spruce st., Newark (7)
Schurman, Emil W., 779 Bergen av., Jersey City (9)
Schwarz, 50 Hauxhurst av., Weehawken (9)
Seeler, Albert O., 236 W. Milton av., Rahway (20)
Shepard, Myron, 435 60th st., West New York (9)
Silverstein, Max, 605 First av., Asbury Park (13)
Smith, Nelson M., 144 S. Harrison st., E. Orange (7)
Sottilaro, Joseph J., 1921 Boulevard, Jersey City (9)
Steuart, David F. R., 9 Armstr'g rd., Morristown(14)
Sullivan, James A., 19 Kensington av., JerseyCity(9)
Talty, John C., 935 Washington st., Hoboken (9)
Tilles, Samuel R., Army
Timlin, James W., 64 Beech st., Arlington (9)
Tocci, Frank P., 74 Grove st., Montclair (7)
Van Wiemokly, S. S., 201 Sp'dwell av., Morrist'n(14)

Walscheid, Arthur J., 404 38th st., Union City (9)
Ward, Chauncey P., 112 Chancellor av., Newark (7)
Wechsler, Joseph, 3342 Boulevard, Jersey City (9)
Weisman Herbert W., 273 Avenue A, Bayonne (9)
Yanowitz, Bernard, 135 Bergen av., Jersey City (9)
Zuloff, D. Blair, 3 Community pl., Morristown (14)

ASSOCIATE MEMBERS

Becker, Meyer, 219 Amboy av., Metuchen (12)
Bristol, Frank E., Main st., Dayton (12)
Brown, Milton B., 72 Roosevelt av., Carteret (12)
Cowen, Mortimer, 1330 Oak Tree rd., Iselin (7)
De Lorenzo, Francis C., 180 Walnut st., Montclair (7)
Dmytriw, Stephen, 226 N. Park st., East Orange (7)
Grubin, Charles J., 1224 Salem av., Hillside (7)
Gurian, Sydney H., 6 Bock av., Newark (7)
McCroskery, Hamilton M., 471 N.Arl'gt'n av.,E.Or. (7)
Murphy, Arthur G., 454 Park st., Up. Montclair (7)
Novak, John G., 111 Clinton av., Newark (7)
Pauly, Arthur N., 105 Willowdale av., Montclair (7)
Pedicini, Joseph L., 588 S. 10th st., Newark (7)
Santangelo, Joseph A., 218 Grafton av., Newark (7)
Svenson, Sven, 36 Prospect ter., E. Orange (7)

OPPORTUNITIES FOR PHYSICIANS

The following notices are published as a service to the physicians of New Jersey. If interested, write to The Medical Society of N. J., 315 West State Street, Trenton 8, and indicate whether you are referring to Notice 1, Notice 2, etc.

1. OPHTHALMOLOGIST, OTOLARYNGOLOGIST, diplomate of Board or eligible for examination this year, wanted as associate to established practitioner in Middlesex County.
2. SURGEON OR SPECIALIST in field other than internal medicine may share office with Jersey City internist and use equipment there.
3. OBSTETRICIAN WITH SOME GENERAL SURGICAL KNOWLEDGE wanted as associate to a Hudson County general practitioner. All equipment will be supplied. Applicant must be under age 40.
4. NINE-ROOM HOUSE, used as M.D.'s office for 25 years, now available.

ASSOCIATES AVAILABLE:

5. PHYSICIAN, AGE 39, INTERESTED IN PART-TIME POSITION as office assistant to general practitioner or industrial surgeon in Newark area.
6. PHYSICIAN, AGE 42, desires placement as office assistant to an obstetrician or general practitioner in Newark area.

OBITUARIES

DR. THOMAS BELL

Northern New Jersey lost one of its most active and useful civic workers with the death, on June 25, of Dr. Thomas Bell. Dr. Bell was stricken with a heart attack while attending patients at a clinic, and after being revived, insisted on continuing his work. Within an hour he suffered a fatal attack. Death occurred at the Newark City Dispensary where he had labored for a quarter of a century, serving during the last decade as Assistant Chief of the Tuberculosis Division.

Born in Kentucky in 1889, he was graduated from the University of Michigan Medical School in 1910. He served an internship and several residencies in the hospitals of New York City, and was on the clinical teaching staff at the medical school of Columbia University. In 1923 he came to Newark, and entered private practice. From the beginning of his stay in New Jersey, however, he was interested in welfare work, and served the City Dispensary and numerous neighborhood houses and welfare agencies. He was on the executive committee of the New Jersey Tuberculosis League, a Trustee of the Fuld Neighborhood House, and at the time of his death, Vice-President of the New Jersey Urban League.

DR. WILLIAM W. MacALISTER

Dr. William W. MacAlister of Paterson, formerly chief of gynecology of the Paterson General Hospital, died at his home in that city on June 22, 1946. Dr. MacAlister was graduated from the College of Physicians and Surgeons in 1899, a member of the first full four-year class which passed through that institution. He interned at St. Joseph's Hospital, Paterson, in 1900 and then served as a resident in surgery at that hospital until 1904, when he opened his office for private practice. He was associate in surgery at Paterson General Hospital for many years, eventually becoming chief of gynecology, and in 1932 president of the medical staff. Dr. MacAlister was also surgeon to the Erie Railroad.

COUNTY SOCIETY REPORTS

BERGEN COUNTY

H. E. Reinhold, M.D., Reporter

Regular meeting of the *Bergen County Medical Society* was held at Bergen Pines Hospital, Oradell, N. J., on May 14, 1946, and was called to order by the president, Dr. Frederick C. Dilger, at 9:30 p. m.

Minutes of the regular meeting of April 9 were accepted as read. The minutes of the Executive Committee meeting of April 16 were approved as published in the *Bulletin*.

Dr. John Irwin, Chairman of the Nominating Committee, presented the following panel of candidates:

For President: Dr. Albert W. Cloud
For Vice-President: Dr. Rudolph C. Schretzmann
For Secretary: Dr. Edward V. Sexton
For Treasurer: Dr. Frederick L. Muller
For Reporter: Dr. Herbert E. Reinhold
State Nominating Committee—Delegate, Dr. Harrison B. Wilson; Alternate, Dr. Frederick G. Dilger
House of Delegates—Delegates, Dr. H. E. Reinhold, Dr. Floyd E. Keir, Dr. Russell K. Tether, Dr. Spencer Snedecor, Dr. Samuel Alexander, Dr. William K. Harryman, Dr. Frederick G. Dilger, Dr. J. H. Irwin; Alternates, Dr. George D. Appold, Dr. William Schmidt, Dr. Willis Demarest, Dr. L. W. Black, Dr. P. A. Groff, Dr. Luke A. Mulligan, Dr. A. F. Padden, Dr. Felix H. Vann.

There were no nominations from the floor.

Dr. Irwin moved that the nominations be closed, and Dr. Grimes seconded the motion.

It was then moved by Dr. Littwin and seconded by Dr. Vroom that the secretary cast one ballot for the entire slate. It was so done and the candidates duly elected.

Applications for membership: To Regular—Dr. Robert J. Gross, Teaneck, N. J. (by transfer from the Medical Society of the County of Kings). To Associate—Dr. Charles P. Campbell, Hackensack; Dr. Eduard Dana, Hackensack; Dr. Stephen Bednarz, Wallington.

Elections to membership—Associate to Regular: Dr. John F. Dally, Teaneck. To Associate: Dr. Nelson C. Walker, Hackensack.

It was regularly moved and seconded that the secretary cast one ballot for the election of the above candidates. It was so done and the candidates were duly elected to membership.

SCIENTIFIC PROGRAM

The speaker of the evening was Dr. Donovan McCune, Professor of Pediatrics, College of Physicians and Surgeons, New York, who spoke on "Diabetes in Children".

The speaker emphasized that diabetes in the child begins with a relatively acute onset as compared with the insidious onset in adults. However, the usual symptoms of polyuria, polydypsia, polyphagia, and rapid loss of weight can usually be elicited.

In the treatment of coma, restoration of sodium chloride and water is the most essential modality. Insulin, glucose and 1/6 molar solution of sodium lactate are also at times necessary.

The diet is calculated on the basis of 80 to 100 calories per kilogram for the infant and 40 to 50 for children around twelve years of age. Fifty per cent of the caloric requirements are provided by carbohydrates, 35 per cent by fat, and 15 percent by proteins. Three and one-half units of insulin are given for every 100 calories in divided doses. After several weeks, most children will do well with 5 units of insulin daily.

After questions were answered from the floor, the meeting adjourned to collation at 10:30 p. m.

CAMDEN COUNTY

Joseph C. Lovett, M.D., Reporter

The *Camden County Medical Society* held its monthly meeting May 7, 1946, at the Camden City Dispensary. Forty members were present. Dr. Robert Gamon, Chairman of the Nominating Committee, presented the following list of candidates, all of whom were elected:

President: H. B. Decker, M.D.
President-elect: J. S. Shipman, M.D.
Vice-President: G. B. German, M.D.
Secretary: A. G. Pratt, M.D.
Treasurer: R. S. Wright, M.D.
Historian: H. F. Schrack, M.D.

The following were recommended for membership to the Society: Dr. John S. Klinger, Dr. Leopold Reiner, Dr. Joseph Skyer, Dr. Nicholas R. Musulin, Dr. Ralph D. Covali, Dr. John J. Jablonski and Dr. Earl B. Keller, Jr.

Dr. William Martin and Dr. Edward Rossell were made honorary members of the Society. Dr. H. E. Yaskin and Dr. Francesco D'Imperio were elected to active membership.

Amendments to the Constitution and By-Laws which were proposed at the April meeting were approved and passed.

It was agreed to have the regular annual outing. Dr. Shipman was made chairman of the Arrangement Committee.

Dr. John Brennan, Dr. E. C. Shull and Dr. E. A. Y. Schellenger were elected to the Nominating Committee for the ensuing year.

Dr. Shull, the treasurer, read his report for the year.

Dr. Schrack, the historian, reported that she is compiling the facts on all the members, past and present, for the past one hundred years.

Dr. Henry Decker, the newly-elected president, addressed the Society giving, as always, an interesting and very appropriate address.

Dr. T. B. Lee read a memoriam on Dr. Grafton E. Day.

MIDDLESEX COUNTY

Alfred J. Barbano, M.D., Reporter

The *Middlesex County Medical Society* met May 15, 1946, at the Roosevelt Hospital, Metuchen. The meeting was called to order at 9:15 p.m. by the president, Dr. C. Howard Rothfuss. Minutes of the previous meeting were read and approved.

Dr. Hoffman, chairman of the Ethics Committee, submitted for associate membership the following names: Drs. Meyer Becker, Milton Brown, Mortimer Cowen, Frank Bristol and Cilfton Myer. All were approved. The following named veterans were then presented for reinstatement: Drs. William Gadek, George Kohut, L. Panigrosso, Sol Gurshman and Norman Reitman. All were approved.

By unanimous vote it was agreed that members of the Middlesex County Medical Society would take part in the all-day outing to be held at Jumping Brook Country Club, Neptune, N. J., on June 19th, 1946.

A letter was read from Esther Brown thanking the Society for the embossed resolution sent to her.

A letter was read from the Prosecutor of Middlesex County relative to the increased number of auto accidents and the coöperation of county physicians in conducting sobriety tests. Judge Melko appeared before the assemblage urging physicians to coöperate with law enforcement authorities in order that drunken driving may be curbed. Captain Steffans of the Police Toxicologic Laboratory of Elizabeth also spoke at length of the various medico-legal aspects of sobriety tests. The Middlesex County Medical Society went on record as being in accord with the county drive for law enforcement especially as it concerned drunken driving.

Dr. Faulkingham discussed the County Welfare Committee fees for medical care. A resolution was adopted concerning care for wards of the State Board of Children's Guardians. A motion was introduced to investigate its application in operative procedures.

Dr. Clarke introduced the speaker, Dr. Frank Smith of New York City, who spoke learnedly on "The Diagnosis and Treatment of Carcinoma of the Uterus".

Motion for adjournment came at 11:30 p.m.

MONMOUTH COUNTY

F. Lawton Hindle, M.D., Reporter

The annual election meeting of the *Monmouth County Medical Society* was held on April 24 at Joseph's Restaurant, Eatontown. After a pleasant interval of fraternization at the bar, the election of officers for the coming year was held during the course of the dinner. Following is the result of the balloting:

President: James P. Pregnall
President-elect: Louis F. Albright
Assistant Secretary and Treasurer (until June, 1948): Michael Q. Handcock
Reporter: Helen Jones
Board of Censors (term of five years): C. Byron Blaisdell
Delegates to the State Convention: Harold H. Freedman, Murray Woronoff, Daniel Featherston, J. George Feman
Alternate Delegates to State Convention: Michael Q. Hancock, Anthony DeVita, Victor Knapp, Samuel Edelson
Nominating Delegate: William G. Herrman
Alternate Nominating Delegate: Daniel Featherston
Delegate to the State Convention: Frank Goff
Executive Committee: Martin Quirk, Frank J. Altschul, C. C. Perrine

Following the dinner, Mr. Edward Mulcahey, of the Lambs Club, entertained the members and guests with many yarns, jokes and anecdotes to the gratification of all with an appreciation for wit and humor. Other than the election of officers, no business was transacted, and the meeting adjourned, leaving the balance of the evening to each one's own nefarious devices.

OCEAN COUNTY

Harvey Rinzler, M.D., Reporter

With the president, Dr. Raymond Taylor, in the chair, the *Ocean County Medical Society* met on June 12 at Wida's Restaurant. The officers recommended by the nominating committee were all elected. In addition to Dr. Taylor, they are: Dr. Bruce Hendrickson, vice-president; Dr. Norman Szold, secretary; Dr. Walter Hayden, treasurer, and Dr. Harvey Rinzler, reporter. After a brief business session, the society settled down to the main activity of the evening, a delicious sea food dinner. This concluded the sessions of the society for the summer, as the next meeting will not be held until September, at a date and place to be announced.

UNION COUNTY

Joseph J. Labow, M.D., Reporter

Annual meeting of the *Union County Medical Society* was held at the Muhlenberg Hospital in Plainfield on April 10, 1946. The president, Dr. Phelan, called the meeting to order at 9 p.m. Minutes of the March 13 meeting and of the Executive Committee meeting of April 8 were read and approved.

Report of the executive secretary was read and received.

Applications for membership were received from Dr. John N. Kennedy, Plainfield, and Dr. Milton Lane, Union.

Candidates elected to membership were: Ralph Ferenchak, Fanwood; Norman W. Gordon, Elizabeth; Sidney Harris, Roselle; Charles J. Hely, Jr., Westfield; Francis B. Nelson, Westfield; Bertram J. L. Sauerbrunn, Elizabeth; Charles A. Speer, Cranford, and Edward E. P. Seldmon, Plainfield, who was accepted as a transfer from Cook County, Illinois.

Drs. Hely, Moon and Sauerbrunn signed the Constitution and were introduced to the Society.

It was moved that Miss Louise Rogers be reappointed executive secretary.

DR. HENRI E. ABEL read the ballot of the Nominating Committee. It was moved that the ballot be accepted as read and the secretary cast a unanimous ballot.

President: E. W. Lance
First Vice-President: S. H. Davis
Second Vice-President: R. M. Nittoli
Secretary: F. W. Lathrop
Treasurer: G. T. Banker
Reporter: E. G. Bourns
Trustee: Irving Lerman (1949)

Board of Censors: H. D. Corbusier (1950), T. J. Walsh (1951)

Scientific and Literary Committee: J. M. Carlisle, David Spivack, R. A. MacBrayer

Finance Committee: Emil Stein (1949)

Legislative Committee: W. J. Hallock (1951)

Medical Service Bureau: W. M. Golden (1949), T. J. Walsh (1950), Beatrice Prazak (1950)

Public Health Committee: H. S. Murphy (1951)

Public Relations Committee: W. H. McCallion (1951)

Nominating Committee: T. J. Walsh; alternate, F. W. Lathrop

Delegates (1948): S. H. Davis; alternate, E. J. Callahan

Delegates: W. F. Phelan, L. G. Brown, Foster Orton, H. M. Glasston, N. W. Burritt, E. G. Bourns, J. E. Franklin, J. E. L. Imbleau, H. S. Murphy, Albert Lewis, T. S. P. Fitch

Alternates: P. J. Kreutz, H. F. Brock, A. E. Breslow, Max Black, Evelyn Holt, M. W. Tyndall, H. J. Konzelman, Richard Wagner, F. H. Brown, C. G. Hanson, R. C. Peters

DR. SEYMOUR, chairman of the Finance Committee, reported for the treasurer the 1945 expenditures and read in detail the 1946 budget. It was moved that the treasurer's report and budget be accepted.

Dr. Phelan, as retiring president, gave an address in which he emphasized the close cooperation between the Society and agencies related to health matters. He stated that compulsory health insurance will not give the adequate medical care as promised in the Wagner-Murray-Dingell Bill and that the medical profession stands ready and willing to lend its wholehearted cooperation to the evolution of plans acceptable to the general public and to the medical and allied professions alike, which will guarantee a more equitable distribution of medical care to all. Dr. Phelan also expressed appreciation to the local press for its interest in the Society.

DR. LANCE accepted the chair from Dr. Phelan and expressed his appreciation to the Society for carrying him as a vice-president while he was serving in the Army Medical Corps for nearly five years.

THE BULLETIN BOARD

The American Congress of Physical Medicine meets September 4 to 7 at the Hotel Pennsylvania in New York City. In addition to the usual scientific program, a systematic three-day course in physical therapy will be given. Details are obtained from the Congress, 30 North Michigan Avenue, Chicago 2.

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A new journal, *The Welfare Reporter*, is being released monthly by the New Jersey Department of Institutions and Agencies. First issue appeared in May, 1946. Because the State Department supervises all state hospitals, this periodical is of special interest to physicians. It includes pictures and information about the state hospitals, about the State Commission for the Blind, about the State Board of Children's Guardians and about the correctional institutions under state control. Copies of *The Welfare Reporter* may be obtained by writing to the Editorial Council of the Department of Institutions and Agencies, 135 West Hanover St., Trenton 7.

The Wisconsin Alumni Research Foundation announces the appointment of Christian P. Segard, M.D., of Leonia, N. J., as medical director as of June 1, 1946.

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An opportunity for an arctic vacation with pay awaits any adventurous doctor who will accept a residency at a hospital in Newfoundland. Salary is $1,000 for the year and full maintenance and travel are provided. Information may be obtained by writing to the International Grenfell Association, 156 Fifth Ave., New York City 11.

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The Revision Committee of the United States Pharmacopoeia announces a return to the prewar formula for liniment of soft soap. This discontinues the use of oil of cedar leaf and returns the formula to the old oil of lavender. The Committee also announces that quindin sulfate tables must now indicate whether the active ingredient was obtained from natural sources or derived from quinine.

WOMAN'S AUXILIARY

PRESIDENT'S MESSAGE

MRS. FREDERICK G. WANDALL

This, my first official message to you through the medium of THE JOURNAL, brings a sincere hope that you will have a pleasant summer and come back to your Auxiliary work with renewed enthusiasm and workable plans for the coming year. Already we have answered the call of our Medical Society, in reminding our husbands to fill in the forms sent out by the chairman of the Academy of Pediatrics of the New Jersey study of child health services.

Expansion must be our key word for the coming season. Our soil is fertile for growth this year. To be a member of the Woman's Auxiliary is a privilege, and every physician's wife in New Jersey should be given that opportunity. Our Auxiliary stands for the protection of the medical profession and since these are perilous times, let us maintain state unity and seek to enlist the interest of those who are eligible for membership, and draw them into our midst.

AUXILIARY REPORTS

Atlantic County

The *Woman's Auxiliary to the Atlantic County Medical Society* honored Mrs. Charles Hyman at a delightful luncheon in the Ambassador Hotel. Mrs. Samuel L. Salasin was chairman of arrangements. Co-chairman was Mrs. James H. Mason, 3rd. Table decorations were beautiful yellow tulips, double lilacs and pink dogwood. Mrs. Bradley presented corsages of white gardenias to the incoming officers. The outgoing president and the incoming president were presented with orchids. Mrs. Salasin congratulated Mrs. Bradley for her successful year, and the newly elected president, Mrs. Charles Hyman, was offered congratulations and best wishes on behalf of the Auxiliary. The Auxiliary is grateful to Mrs. Edward Guion, Mrs. Alan Reick and Mrs. Homer Silvers for the floral decorations. Tables were beautifully decorated by Mrs. Mason, co-chairman of luncheon arrangements.

The meeting was conducted by the outgoing president, Mrs. Robert A. Bradley, who successfully concluded the year 1945-1946. Mrs. Bradley's annual report was as follows: "We have come to the close of another successful Auxiliary year. We have fulfilled the purposes for which we are organized, to promote good fellowship amongst physicians' families and to assist the Atlantic County Medical Society as they approved or suggested." Many interesting reports were presented from the standing committee chairman of 1945-1946.

Mrs. Daniel C. Reyner presented the following reports for the nominating committee 1945-1946: President-Elect, Mrs. Edward H. Dyer; First Vice-President, Mrs. William Roop; Second Vice-President, Mrs. Harry Subin; Secretary, Mrs. Irving Shavelson, and Treasurer, Mrs. Raymond A. Williams. Mrs. Robert A. Bradley conducted the election and the installation of officers following the report. Mrs. Charles Hyman was installed as president along with the other newly elected candidates.

Four new members were admitted to membership. 1945-1946. Mrs. Roland DeHellenbranth, Mrs. Thomas Pettinga, Mrs. C. A. Milano and Mrs. F. Rolfe Westney. The following new members were admitted 1946-1947: Mrs. Samuel Kaman, Mrs. Samuel Halpern and Mrs. Martin Green.

NURSES LOAN FUND

The Woman's Auxiliary in Atlantic County now sponsors a student nurses loan fund. Aim of this fund is to help, through a loan, an ambitious, conscientious girl who needs such assistance. The applicant must have been a resident of Atlantic County for at least four years and must meet all the requirements for admission to the School of Nursing of the Atlantic City Hospital. Candidates should submit their application, together with high school credentials, to Mrs. Lawrence Wilson of 114 North Shore Road, Absecon, N. J.

Camden County

Mrs. Thomas H. McGlade, Chairman of Publicity

The Annual Luncheon Meeting of the *Woman's Auxiliary to the Camden County Medical Society* was held on May 7th, 1946, at the Log Cabin Lodge, Medford Lakes.

Mrs. Reuben L. Sharp, president, welcomed the members and guests and presided over a short business meeting. She presented Mrs. Frederick G. Wandall, State President-Elect, and Mrs. F. M. Percival, Councillor of the First District of Pennsylvania Medical Auxiliary, as distinguished guests.

Installation of officers then took place. Officers for the year 1946-1947 are as follows: *President,* Mrs. A. Lincoln Sherk; *President-Elect,* Mrs. A. Gomersall Pratt; *First Vice-President,* Mrs. Harold D. Barnshaw; *Second Vice-President,* Mrs. Gerald W. Husted; *Third Vice-President,* Mrs. A. M. K. Maldeis; *Treasurer,* Mrs. Banks S. Baker; *Recording Secretary,* Mrs. Harold K. Eynon, and *Corresponding Secretary,* Mrs. Thomas H. McGlade.

Mrs. A. Haines Lippincott presented the Past President's Pin to Mrs. Reuben L. Sharp.

Mrs. A. Lincoln Sherk announced her committee chairmen for the coming year.

Mr. Francis Boswarth, director of the Friends Neighborhood Guild, Philadelphia, Pa., spoke on "Intimate Glimpses Back Stage in New York." Using Macbeth as an illustration, Mr. Boswarth gave a most interesting and stimulating talk on the intricacies involved in the production of a play.

Essex County

Mrs. Rocco Marra, Chairman of Publicity

The *Woman's Auxiliary to the Essex County Medical Society* held their annual luncheon at the Academy of Medicine on May 27, 1946, and elected and installed their new officers.

Mrs. S. Bernard Kaplan of East Orange, the retiring president, reviewed the activities of the last year and reported the addition of 36 new members into the Auxiliary during the past year. She expressed her appreciation for the cooperation received from the chairmen who served under her during her term in office, and to the Auxiliary members.

Mrs. Don Epler presented a resume of her recent attendance at the Auxiliary convention at Atlantic City. She outlined the topics of discussion for each day of the convention, which was interesting and enlightening.

A gift of $250 to the benevolent fund of the Medical Society was voted and the motion for action was offered by Mrs. Louis Schneider.

Mrs. Kaplan installed the new president, Mrs. Frank S. Forte of Newark, and the other officers, which included: President-elect, Mrs. D. E. Kavanaugh of Newark; vice-presidents, Mrs. Otto Matheke, Jr., and Mrs. Manfred Kraemer of Newark; treasurer, Mrs. Philip J. Santora of Newark; corresponding secretary and director, Mrs. Rocco Marra of Orange; recording secretary, Mrs. V. J. Riggs of East Orange; director, Mrs. T. R. Robie of Montclair.

Mrs. Forte expressed her desire to carry on the good work of the Auxiliary as in the past. She was presented with flowers by the Morgagni Woman's Club.

On March 25, 1946, the *Woman's Auxiliary to the Essex County Medical Society* held their meeting at the Academy of Medicine. Dr. Harrold A. Murray of Newark acted as chairman. The topic was child welfare, and the guest speakers included Dr. Murray, Miss Jessie Stanton, consultant on nursery schools, and Dr. Edward P. Duffy, Jr., of Nutley. Mrs. E. V. Berney, child welfare chairman, presented the speakers.

Establishment of diagnostic clinics to seek the causes of behavior problems in early childhood is planned by the Essex County Medical Society. Dr. Murray reported that it would take some years to get such clinics under way. He said there is need to find the cause of temper tantrums and other conduct problems which face parents and teachers. As such deviations from the normal are symptoms of some disturbance, physical or otherwise, treatment should be preceded by diagnosis, he added.

Miss Stanton gave instances from her own experience in dealing with children. Never, she said, has she found young children so emotionally disturbed as now; and never have they so needed reassurance from parents and teachers. She urged more thoughtful study of the child.

Dr. Duffy stated that in his experience, it was the parent who was chiefly at fault. All children act differently and present a different problem. It is the parents who should study their children carefully and treat them accordingly.

Mrs. S. Bernard Kaplan, the Auxiliary president, presided and conducted executive and business meetings preceding the child welfare session.

Gloucester County

Mrs. Clarence Bowersox, Publicity Chairman

The *Woman's Auxiliary to the Gloucester County Medical Society* held an open health meeting Friday, April 26th, 2 p. m., at the Presbyterian Church, Broad Street, Woodbury.

Mrs. Frederick Faux, president of the Auxiliary, extended a welcome to about sixty guests and members.

Program chairman, Mrs. Frederick Wandell of Clayton, presented Dr. Frederick Faux of Woodbury, who gave a brief talk prior to the showing of the Navy film, "Medicine in Action."

Mrs. Wandall then presented Dr. Henry A. Davidson of Newark, whose topic was "Quackery in Medicine". He said that the only cure for quackery in medicine is information. Dr. Davidson's subject was illustrated by photostats of testimonials, many of which were most humerous.

Refreshments were served by the committee.

Mrs. Frederick Wandall of Clayton entertained the *Woman's Auxiliary to the Gloucester County Medical Society* at a luncheon on May 9th.

There were fourteen members present.

Following the luncheon, the annual business meeting was held with Mrs. Frederick Faux presiding. The election of officers was as follows: Mrs. Joseph Hughes, Woodbury, president; Mrs. C. I. Ulmer, Gibbstown, president-elect; Mrs. P. M. Pegau, Woodbury, vice-president; Mrs. George Booth, Westville, treasurer; Mrs. Louis Collins, of Glassboro, secretary.

Mrs. Faux appointed as first delegates to the State Auxiliary Convention to be held in Atlantic City on May 21, 22 and 23, Mrs. A. G. Campo of Westville and Mrs. David Brewer, Jr., of Woodbury. Alternates appointed were Mrs. William Pedrick and Mrs. Joseph Hughes.

Hudson County

Mrs. Sydney Chayes, Chairman of Publicity

A regular monthly meeting of the *Woman's Auxiliary to the Hudson County Medical Society* was held April 1, 1946, at the Young Women's Christian Association, Jersey City.

Mrs. Edward Murphy presided and reported on the State Auxiliary meeting held at Trenton during March.

Mrs. Richard Lempke was introduced and welcomed into the membership of the Auxiliary by our President.

Mrs. Carl Tannert and Mrs. Arthur Largay are co-chairmen of the Spring Luncheon and Card Party to be held at the Crestmont Country Club of West Orange in May.

Tea was served after the meeting with Mrs. Samuel Barishaw pouring.

The *Woman's Auxiliary to the Hudson County Medical Society* held a regular meeting May 6, 1946, at the Young Women's Christian Association, Jersey City. Mrs. Edward Murphy presided. Annual reports were given by the officers and committee chairmen.

Mrs. Murphy paid tribute to the memory of Mrs. Minnie Freile, the first president of the Hudson County Auxiliary, who recently passed away.

The Auxiliary established a Minnie Freile Memorial in the form of an essay contest each year for Senior High School students. The subject will relate to medicine and a $25 prize will be presented to the winning contestant at the annual Reciprocity Meeting.

The cancer drive was discussed and an urgent appeal was made for assistance.

Delegates named to attend the 1946 State Convention at Atlantic City are Mrs. Abraham Jaffin, Mrs. Samuel Barishaw, Mrs. Louis Perkel and Mrs. F. A. Figurelli with Mrs. Arthur Largay and Mrs. Sydney Chayes alternates.

Plans were completed for the Spring Luncheon and Card Party to be held at the Crestmont Country Club, West Orange, on May 28. Mrs. Arthur Largay is chairman.

Mrs. Krevin Leir of Jersey City was introduced and welcomed as a new member.

Tea was served with Mrs. John Nevin pouring.

Mercer County

Mrs. C. Chester Chianese, Publicity Chairman

The *Woman's Auxiliary to the Mercer County Medical Society* sponsored a Public Relations meeting and tea on April 9th, 1946, in the New Jersey Medical Society Home in Trenton.

Mrs. H. Donald Cowlbeck, President, presided. The symposium on "nutrition" included the following: A colored sound movie, "Proof of the Pudding"; a talk by Miss Mary Doermann, extension specialist in nutrition, New Jersey College for Women; "The Treatment of Weight Reduction" by Dr. S. William Kalb, nutrition representative of the State Medical Society, and a round table discussion on personal nutrition problems.

Following the program, tea was served.

Mrs. Thomas V. Murto, public relations chairman, was assisted by the following hostesses: Mrs. C. Chester Chianese, Mrs. R. J. Cottone, Mrs. Charles C. Cohan, Mrs. Paul J. Finegan, Mrs. William C. Ivins, Mrs. John F. Kustrup, Mrs. E. F. Purcell and Mrs. LeRoy A. Wilkes.

Mrs. William E. Dodd, State Auxiliary President, was the guest of honor.

The *Woman's Auxiliary to the Mercer County Medical Society* held their annual meeting May 7. Mrs. H. Donald Cowlbeck, President, presided.

Annual reports were submitted by the chairmen of the various committees. Mrs. Robert J. Cottone, Nominating Committee Chairman, presented the slate of officers for the coming year. Newly elected officers are as follows: President, Mrs. Ernest F. Purcell; President-Elect, Mrs. John F. Kustrup; First Vice-President, Mrs. C. Chester Chianese; Second Vice-President, Mrs. LeRoy A. Wilkes; Recording Secretary, Mrs. Charles C. Cohan; Corresponding Secretary, Mrs. William E. McCarthy; Treasurer, Mrs. George F. Hutchinson; Advisory Board: Mrs. H. Donald Cowlbeck, Mrs. Robert J. Cottone, Mrs. George N. J. Sommer.

Luncheon was served at the Carteret Club.

Ocean County

Mrs. Emanuel Sickel, Chairman of Publicity

The first Ladies' Night Dinner in honor of the *Woman's Auxiliary to the Ocean County Medical Society* was held April 11, 1946, at The Laurel-in-the-Pines. This is the first social event held by the Ocean County Medical Society in five years, since during the war all social activities were definitely foregone.

Dr. Abraham Goldstein, president of the Ocean County Medical Society, greeted the guests and introduced them to Dr. Samuel Alexander, President of The Medical Society of New Jersey, who later gave an interesting report of the highlights of the activities of The Medical Society of New Jersey.

Mrs. Mabel Dodd, wife of Dr. William E. Dodd, was the honored guest, as she is the President of the Woman's Auxiliary to The Medical Society of New Jersey. She gave a most inspiring address. Mrs. Dodd is also a past president of the Woman's Auxiliary to the Ocean County Auxiliary. Final speaker of the evening was Mrs. Carl Menge, president of the Woman's Auxiliary to the Ocean County Medical Society.

Dr. Goldstein in his final address asked all to stand a moment in silent prayer in memory of Dr. Citta of Toms River, N. J., a member of the Ocean County Medical Society, who was killed during the World War II.

After dinner, a floor show was held in the Burgundy Room. Dr. Adolph Towbin was the chairman of entertainment for this affair, and was responsible for the success of this very lovely party.

BOOK REVIEWS

The Care of the Aged (Geriatrics). Fifth Edition. By M. W. Thewlis, M.D. Pp. 500, with 65 illustrations. St. Louis, C. V. Mosby Co. 1946. $8.00.

When the first edition of this text book was published less than 5 per cent of the population were over 60. Today with the fifth edition, this figure is well over 10 per cent and may be 15 per cent in another year. At that level it will exceed the population under ten years of age. To put it bluntly, the aging will need many more physicians who are especially interested in geriatrics.

The anatomic, physiologic, pathologic and mental changes that occur in the aging are still problems to the medical profession. That they can be aided and, at times, greatly benefited is the message that Dr. Thewlis brings to those who will join him in specializing, at least to some extent, in the field of geriatrics.

A new chapter on anesthesia by Dr. D. L. Burdick shows how to lessen the risk and widen the usefulness of surgery. This chapter together with the one on surgery in the aged are practical guides in this field.

Two chapters on diagnostic errors and on therapeutics are in themselves a mine of information, not only in geriatrics, but in all branches of medicine.

The author has stressed the fact that history taking is the most important part of the physical examination. Here we find from the patient and from relatives the many quirks, habits, excesses and other characteristics that, over the period of years, has led to the individual before you. It is a fascinating field for anyone and for the physician who can become social, economic and medical counsellor to the aging this book is itself a guide.

CHRISTIAN P. SEGARD, M.D.

Protein Nutrition in Health and Disease. Edited by G. K. Anderson, M.D., Secretary, Council on Foods and Nutrition, American Medical Association; published 1945 by the American Medical Association, reprinted 1946 by Mead Johnson and Company. (Gratis.)

Nine articles, previously published in the *Journal of the American Medical Association,* are here reprinted and assembled to form a compact pocket-size 125-page book, distributed gratis to physicians by an Evansville, Indiana, manufacturer. The subjects covered include protein nutrition in obstetrics and pediatrics, the clinical detection of protein deficiency and the selection of proper diets. Practitioners interested in familiarizing themselves with the problem of protein metabolism will find this booklet a handy and useful compendium of practical information on the subject. An alphabetical index sharpens the usefulness of the book as a clinical tool. The entire text can be read in two hours and for the internist, pediatrician, obstetrician or general practitioner, it will be time well spent.

Narcotics and Drug Addiction. By Erich Hesse, M.D. Pp. 219. New York. Philosophical Library, 1946. ($3.75.)

On the title page, the author appears simply as "Erich Hesse, M.D." The publisher's wrapper identifies him as "Professor of Pharmacology and Biology"—but it does not say where. It would be interesting to know the author's qualifications. While the pharmacologic aspects of drugs are well treated, clinical material for the most part is vague, obsolete, and sometimes incorrect. Thus, contrary to current thinking, he classes alcohol as a stimulant, tobacco as a chronic, habit-forming intoxicant, and describes the end-result of marihuana absorption as "incurable dementia". He urges doctors "to take a stand against tobacco, to make it clear to the masses that tobacco is dangerous". The legal, statistical and scientific citations are, for the most part, from German sources. It is hard to see how an American physician would be interested in knowing what paragraph of what section of the prewar German Civil Code applies to the legal status of an opium addict. The treatment suggested for the various addictions is the sort of routine taught to undergraduate medical students four decades ago. "The final result of morphine treatment depends on keeping the patient's mind off all disturbing factors"—for instance. It is unlikely that any doctor will ever wear the covers off this book.

Medical Services by Government. By B. J. Stern, Ph.D. Pp. 208. New York. Commonwealth Fund. 1946. ($1.50.)

In 1942 the New York Academy of Medicine instructed a Committee to "review the nature, quality and direction of the economic and social changes now taking place or to be anticipated and to define how these changes are likely to affect medicine". The present volume is one of a series of monographs documenting the work of that committee. It is a serious and solemn analysis of the medical and hospital services offered by local, state and federal government agencies. The book bristles with dates and statistics, though the writing style is somewhat pedestrian. The author has a fondness for long sentences. "Although state responsibility for persons in need has always been and continues to be secondary to the responsibility of local governments, since the passage of the federal Social Security Act in 1935 many states have begun to assume some supervisory and financial responsibility for permanent general relief and public assistance programs." That is the opening sentence of one of the chapters, and opening sentences, of course, are always breezier and more attention-arresting than sentences deep in the text. If a doctor is willing to plow through this kind of language, the book will reward him with a battery of facts, historical and statistical, about government activities in the field of individual health. The author has apparently aimed at scientific objectivity, and has achieved

that aim so well that the fact-packed paragraphs are undiluted by anything so subjective as an opinion or a comment. The doctor who wants to orient himself to the historical background of the subject will find an exhaustive (though perhaps exhausting) treatment of it here.

Symptoms of Visceral Disease: A Study of the Vegetative Nervous System in Its Relationship to Clinical Medicine. By Francis M. Pottenger, M.D. 6th ed. Pp. 442 with 97 illustrations. St. Louis. C. V. Mosby Co. 1944. $5.00.

The practice of medicine is a continuing attempt on the part of physicians to understand how the patient expresses disease through symptoms. The usual clinical text-book suffers from the defect that it lists symptoms rather than explains them. The ordinary physiology text errs in the opposite direction; it furnishes explanations but fails to make the explanations a vital part of clinical practice. Pottenger's book, now in its sixth edition, is a unique effort to bridge that gap. The orientation is somewhat narrow in that it restricts itself largely to reflex mechanisms; but this narrowness does result in a sharp focussing on visceral neurology. The author reviews, in considerable detail, reflex spasms and referred pain. His emphasis is always on the total organism, on how disease in one organ gears into function in another.

The book is divided into three parts. The first deals with the anatomy, pharmacology and physiology of the vegetative nervous system. In Part II, the relationship between the vegetative nervous system, on one hand, and clinical symptomatology, on the other, is carefully explored. In the final section, there is a chapter devoted to each major viscus with an analysis of its innervation and an explanation of its symptomatology.

Current Therapies of Personality Disorders. Edited by Bernard Glueck, M.D. Grune and Stratton, New York, 1946.

The vagueness of the sections on therapy has long been a grievance of readers of psychiatric texts. Comparatively few books have been written primarily about treatment in psychiatry. It is therefore, with considerable hope, that the reader will turn to the present volume. The book is made up of papers given before the American Psychopathological Association in 1945.

Unfortunately the present volume suffers from the same defect. There is much discussion about treatment, but little concrete description of actual technic. Louis Wender's paper on group therapy is an exception. Here the author does lay down the method on a "how to do it" basis. The same may be said of Joseph Thimann's chapter on the condition reflex treatment for alcoholics. Here too, exact technics including (an unexpected item in a psychiatric text) actual prescriptions! And Thomas Verner Moore's talk on bibliotherapy is challenging, interesting, and to those who want to try it, practical. Otherwise the papers are well-written, highly motivated, and not translatable into actual treatment technics. It may be said that psychiatry is an art not a science, that its therapeutic methods are of such gossamer delicacy that they fall apart when subjected to a crude one, two, three method of exposition. This may be true, but the fact remains that skilled psychotherapists who have mastered the art, do not need this book; and others can not profit from it.

The book consists of nineteen papers covering such items as personal rehabilitation, psychoanalysis, group therapy, convulsive therapies, reconditioning, bibliotherapy, hypnoanalysis, family guidance and child psychiatry.

Medical Books Published During 1945. Published 1946 by Mead Johnson and Company, Evansville, Indiana. Gratis.

Although this 72-page booklet will be sent without charge to any physician, it may turn out to be an expensive gift. It will be hard for the alert practitioner to leaf through these pages without deciding that he must have one or another of the new books. The listings are alphabetical by specialty, with a cross-indexing by authors and an address list of publishers. Following the title of each book is the author, retail price and name of the publisher; and then a paragraph of a favorable review or a selection from the publisher's blurb. This is therefore a simple catalogue and not by any means a critical review of the books published during 1945. In spite of the fact that all texts mentioned are seen through uniformly rose-colored glasses, the booklet fills a useful—and unique—place in American medical literature. There is nothing quite like it. It is invaluable to medical librarians, to physicians serving on the library committee of a hospital or professional society, to recently demobilized doctors who want to know what has just been published in their special fields, and to any doctor who prides himself on keeping up with the world of medical literature.

In the Doctor's Office. The Art of Being a Medical Assistant. By Esther J. Parsons. 2d Printing. Lippincott, 1946, Philadelphia. $2.00.

You might give this book to a new receptionist, nurse or secretary in your office. It is packed with practical pointers on how to talk to new patients, first aid, preparation for diagnostic and therapeutic procedures, office filing, medical bookkeeping, tips on securing information from patients, removing stains and cleaning instruments. Not that the volume is unadulterated gold. Indeed, the first forty pages or so are pure pap. Advice on "taking criticism graciously", or "listen to details when receiving instructions" or take breathing and stretching exercises every morning at 7 a. m. However, the girl can skip the detailing of the obvious in the first three chapters, and really sink her teeth into something useful in the rest of the book. The advice is illustrated by numerous and appropriate anecdotes and enlivened by many witty line sketches drawn by Jean McConnell. Aside from the unfortunate first three chapters, the table of contents includes items on receiving the patient, preparing records, preparing patients, emergency care, telephone technic, handling correspondence, and office housekeeping.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XIX **July, 1946** **No. 7**

MINIMAL pulmonary tuberculosis is a relatively new disease to most physicians because its recognition has awaited the general employment of improved X-ray techniques. Our familiarity with the classical findings and symptoms of *advanced* tuberculosis may be the very factor which causes us to overlook ill-defined manifestations of *early* tuberculosis. Here the X-ray often provides the missing clue.

THE EARLY DIAGNOSIS OF MINIMAL PULMONARY TUBERCULOSIS

There are numerous vital reasons that indicate the importance of diagnosing tuberculosis in the minimal stage. The percentage of arrested or healed cases is highest, and the time required to obtain an arrest of the disease much the shortest in minimal cases. Collapse measures are infrequent and when used are less extensive, with complications, morbidity and mortality therapy reduced. The minimal cases, moreover, have far fewer recurrences. The percentage of those employed or able to work after treatment is much higher in this group.

The public benefits from the early diagnosis and cure of the disease. In persons with positive sputum, the spread of tuberculosis to their families and friends and the community is avoided. The shorter hospitalization period required for minimal cases means that public expenditures for them and their families are thereby definitely lowered.

To determine the factors that could aid the making of an early diagnosis, 200 cases with minimal lesions were studied. These patients were consecutive admissions to the Otisville Sanatorium, and all the cases were minimal on admission, according to the standards of the National Tuberculosis Association. Of the entire series, 155 patients were between the ages of fifteen and thirty-five. Forty-five patients were over thirty-five years old, with 20 of them older than forty. There has not been enough emphasis on the fact that tuberculosis often occurs in the elderly. Far too frequently the symptoms of older people are explained on the basis of other conditions, such as chronic bronchitis, asthma or winter or cigarette cough. The 200 patients were quite evenly distributed according to sex and marital status. Several races and over forty different occupations were represented indicating that tuberculosis should be suspected at any age, in any occupation and with any type of social or economic background.

Sixty-seven patients (34 per cent) had had some contact with tuberculosis. A history of contact with this disease indicates that the patient obviously has had opporunities to become infected. The high tuberculosis morbidity and mortality rate for those with household contact has often been emphasized and the danger for children has been stressed. Every person who has had contact with tuberculosis patients should have a complete examination, including X-ray, at once. This should be repeated every year, and preferably every six months. Lack of contact, however, does not rule out the presence of tuberculosis.

Of these 200 patients, only 37 (19 per cent) were without symptoms. One hundred and fifty-five patients had specific complaints, and eight gave a history of pleurisy. The statement has often been made that minimal tuberculosis is asymptomatic. This study significantly shows that the great majority of these patients do have symptoms. Certain symptoms are particularly frequent in minimal tuberculosis. Unfortunately, however, these are not characteristic or specific for this disease. Symptoms in themselves cannot serve as the sole criterion for the diagnosis of tuberculosis, but when present they should definitely suggest a chest X-ray examination.

Besides contact and routine examinations, the only factor that aided early diagnosis in this series was an acute onset or hemoptysis that prompted an immediate medical check-up. There is need for

education of the public to consult physicians early regarding symptoms. The importance of the symptoms should be stressed, especially those that are not striking in character. In 21 patients a diagnosis of tuberculosis was not suspected or made at the first medical consultation.

Almost 75 per cent of the errors were in diagnosis of nontuberculous respiratory or upper respiratory conditions. To prevent these errors, it should be a routine practice not to make a diagnosis of pneumonia, bronchitis, asthma, pleurisy, chest cold, catarrhal fever or grippe without first considering tuberculosis. The symptoms and physical findings in these cases may be those encountered in tuberculosis. To determine definitely the presence of tuberculosis an X-ray and sputum examination and occasionally a tuberculin test are requisite for all these patients. This would not be an impractical or uneconomical procedure, for the yield of active cases of tuberculosis would be considerable.

The most valuable diagnostic physical finding in tuberculosis is the presence of rales, but only 29 per cent of these 200 minimal cases had rales. In minimal tuberculosis a normal physical examination is usual.

The demonstration of tubercle bacilli is, of course, absolute proof of tuberculosis, but the presence of a negative sputum does not mean that tuberculosis is absent. This is particularly true in minimal cases. In this series, 78 per cent were without positive sputum.

It is not necessary to wait for a positive sputum to make a diagnosis of minimal tuberculosis, since an early X-ray examination, properly followed up, will indicate the disease. Needless to say, in a case with a purulent sputum persistently negative for tubercle bacilli, tuberculosis is undoubtedly not present. Other laboratory findings were of little help in diagnosis.

The physician in general practice can be extremely valuable in finding cases of tuberculosis. The patients that come to physicians' offices are a fertile field for mass surveys. It is estimated that 30 per cent of the general population visit a physician during the year. Fluoroscopy is of definite value and is much better than a physical examination for the discovery of minimal cases, but it cannot be relied on solely for diagnosis. To be certain of the presence or absence of tuberculosis, it would be necessary to X-ray patients considered negative on fluoroscopy.

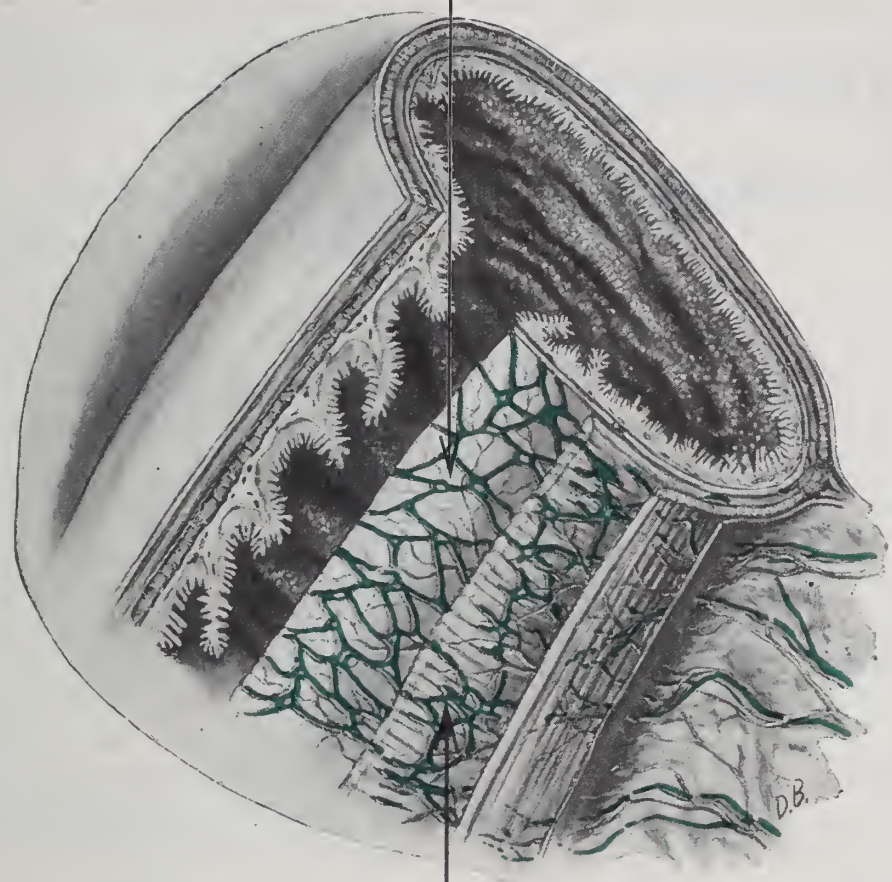
The main problem in the control of tuberculosis is that of early diagnosis. As the next step, however, treatment should be provided without delay. It is the duty of the physician to educate the patient and his family in the infectiousness of the disease and of the value and necessity of immediate care. A patient may delay proper attention at home, postpone seeking admission to the sanatorium or continue to work after the diagnosis because necessary home adjustments have not been made. To meet these situations requires the cooperation of public or voluntary social service and welfare associations and of public health nursing and medical groups. If such problems are taken care of, patients will be prompted to accept medical treatment as soon as the diagnosis has been made. The possibility of progression of the disease can then be diminished and the morbidity and mortality of advanced tuberculosis thereby avoided.

The Early Diagnosis of Minimal Pulmonary Tuberculosis, I. D. Bobrowitz, M.D., and Ralph E. Dwork, M.D. The New England Journal of Medicine, January 3, 1946.

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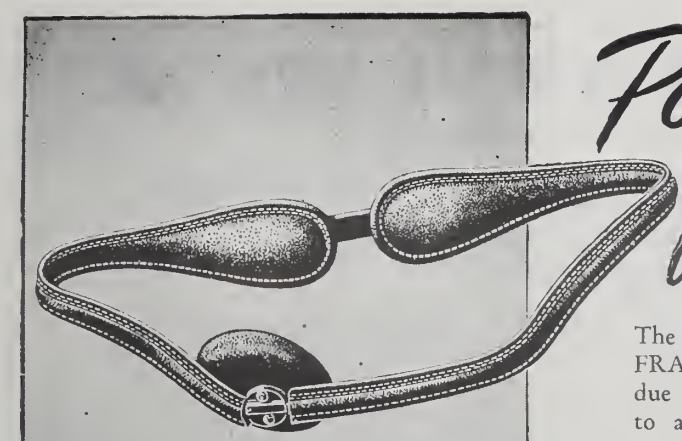
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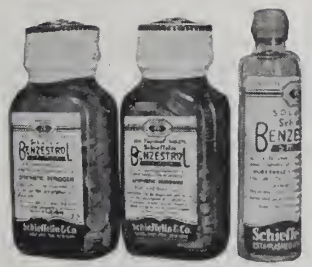
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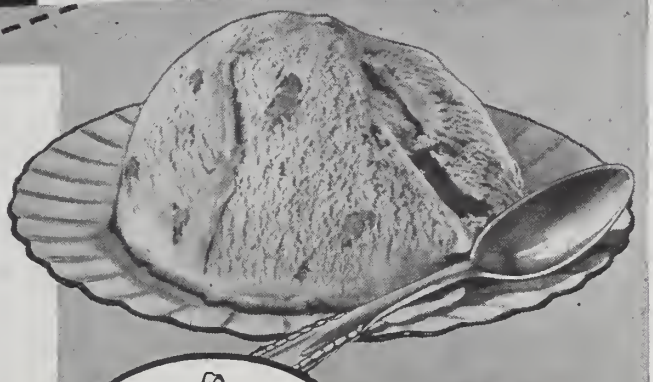
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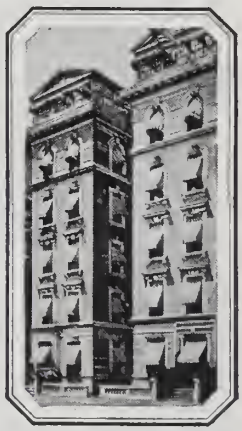
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VOL. 43, NO. 8 AUGUST, 1946 Subscriptions, $3.00 per Year
Single Copies, 30 Cents

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Place of Publication, Printing and Mailing:
12 South Day St., Orange, N. J.

Editorial and Executive Offices of the Society:
315 West State St., Trenton 8, N. J.

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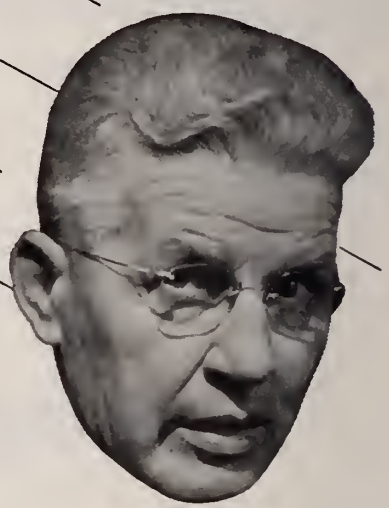
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* *Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154*
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60

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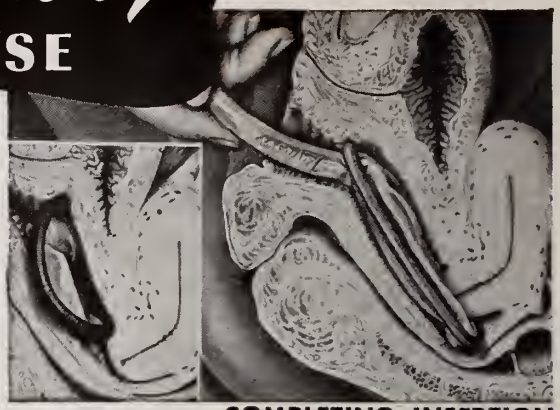
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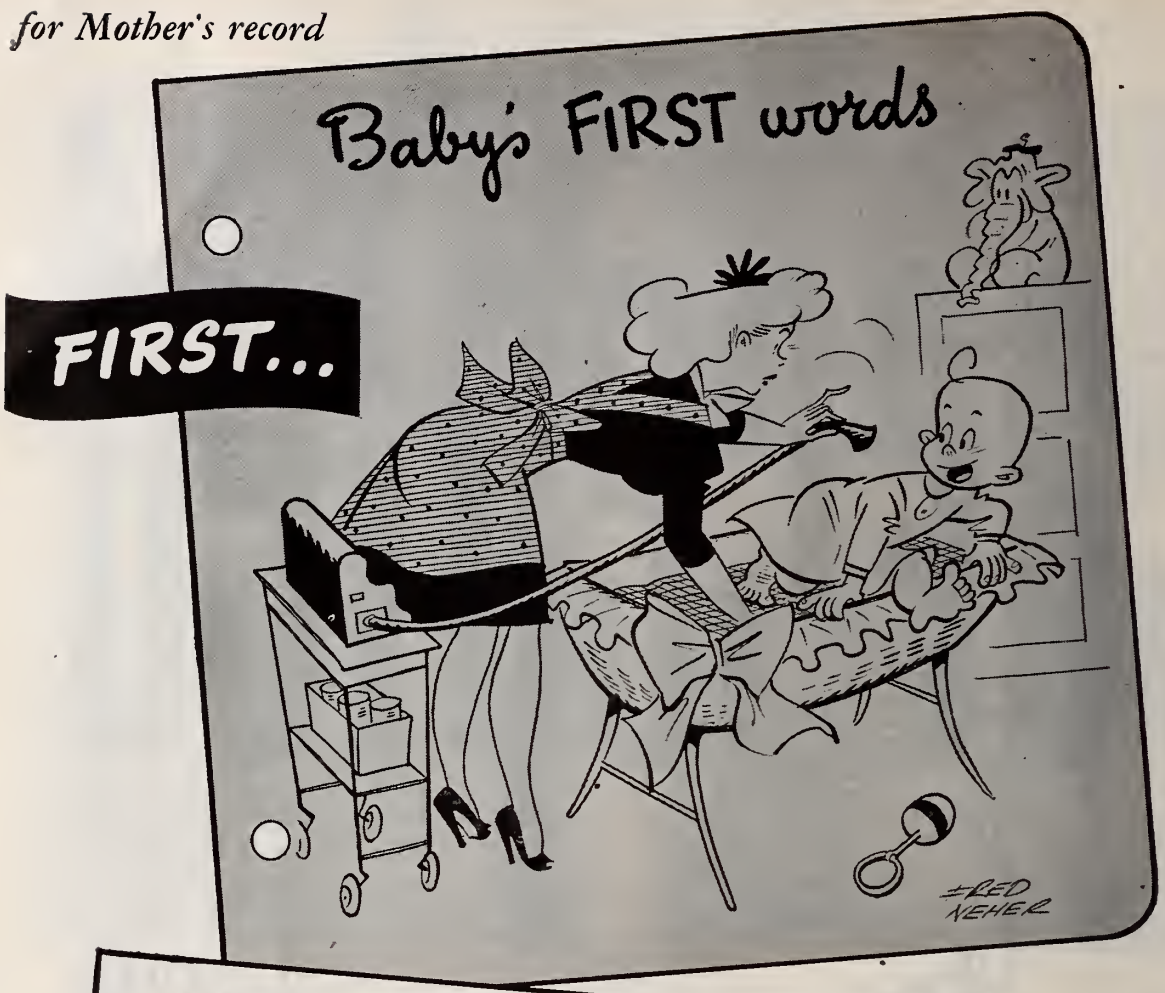
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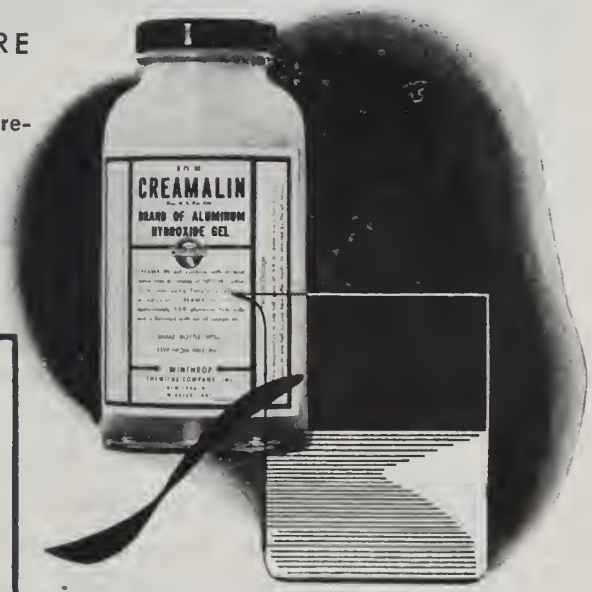
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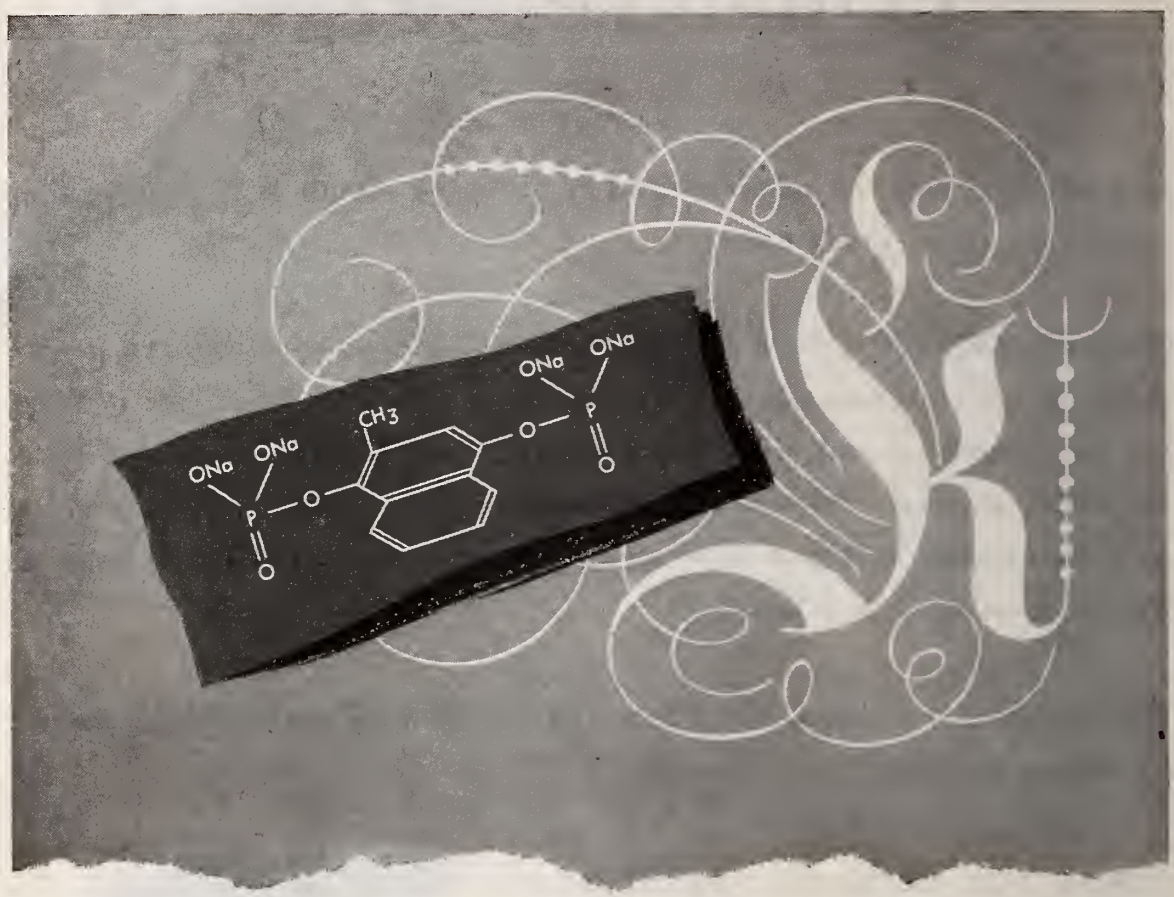
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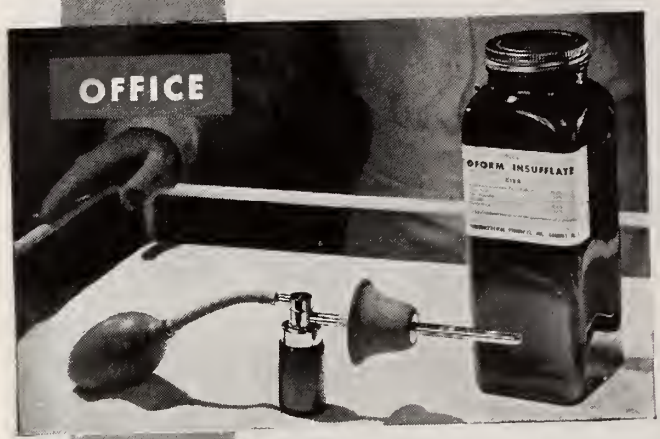
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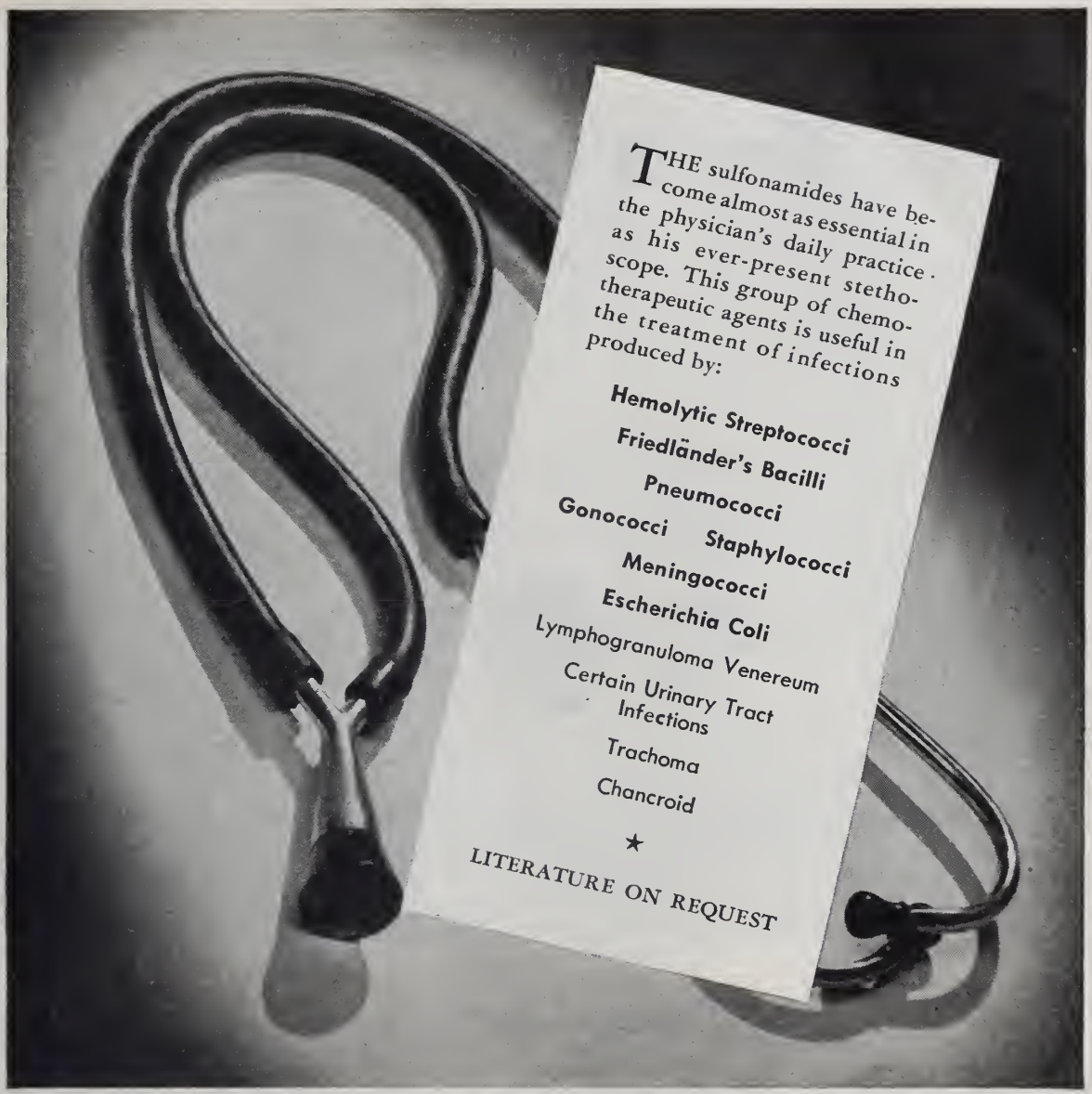
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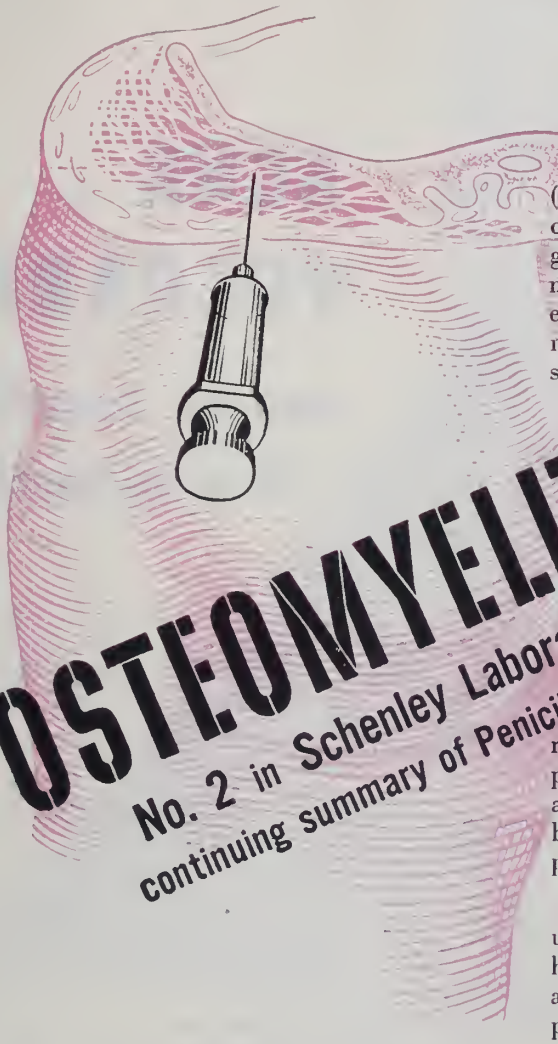
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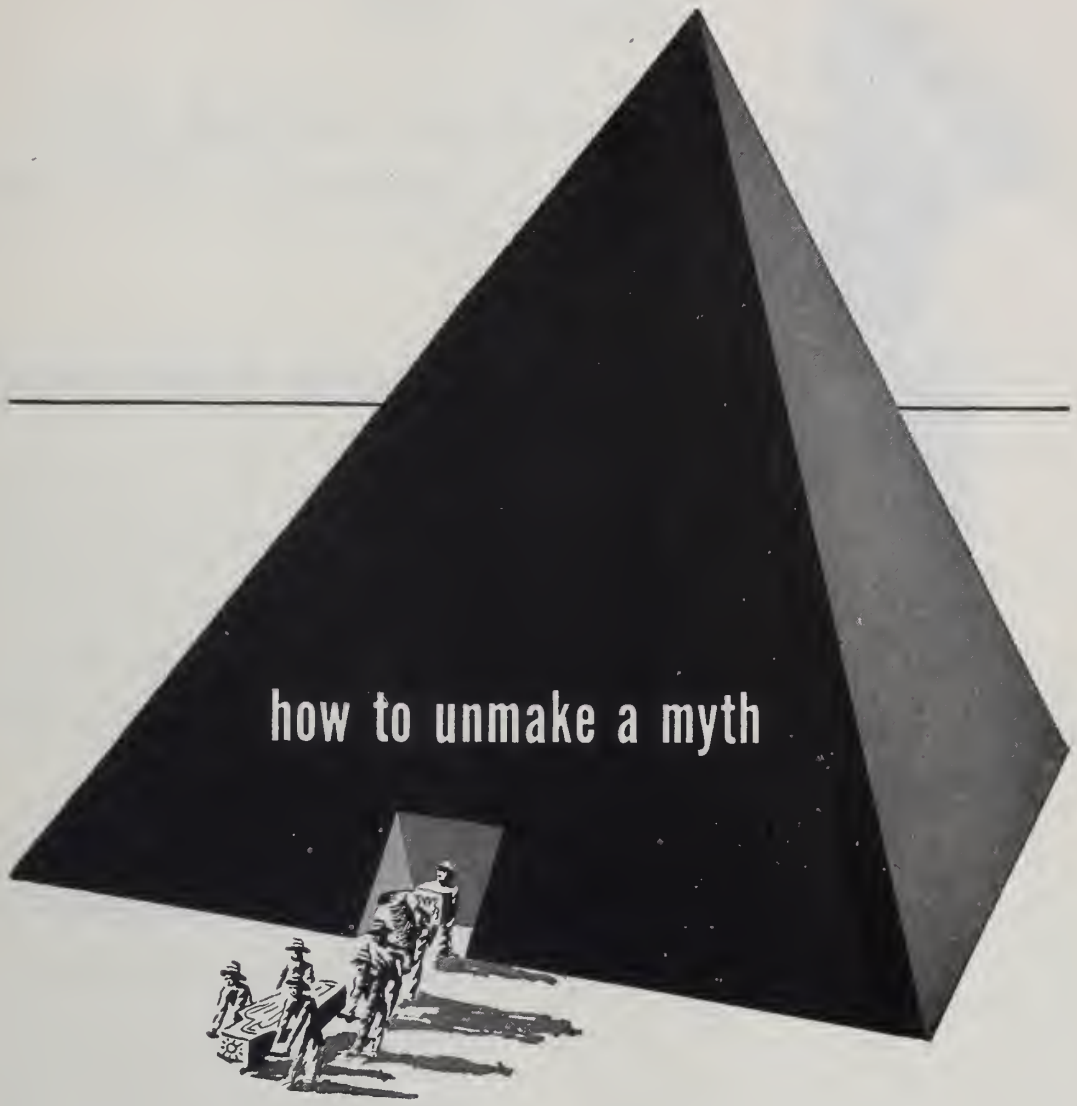
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1. Am. J. Dis. Child. 66:1 (July) 1943

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THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Published Monthly Since September, 1904

Whole Number of Issues, 504

Under the
Direction of the
Committee on Publication

Henry C. Barkhorn, M.D., Chairman

Henry A. Davidson, M.D., Editor

Place of Publication, Printing and Mailing—12 South Day Street, Orange, N. J.
Editorial and Executive Offices of the Society—315 West State Street, Trenton 8, N. J.; Tel 5776
Send all communications to the Trenton Office
Each member of the State Society is entitled to receive a copy of The Journal every month.

Vol. 43, No. 8 August, 1946 Subscriptions, $3.00 per Year
Single Copies, 30 Cents

MARGINS OF MEDICINE

In our concern about government encroachment on the field of private practice, we sometimes forget that less dramatic, just as serious and much more preventable, is the erosion of the marginal healing disciplines into the area of medicine. These marginal activities are the quasi-medical practices which haunt the fringe of the profession: chiropody, optometry, commercial roentgenology, lay masseurs, and the like. In our naivete, inertia or indifference, we have allowed much of the periphery of medicine to go by default to these practitioners. These nibblers at medicine's margin fall into two groups: those who are all right in their place; and those who have no place. Tackling the latter problem is perhaps the job of organized medicine and the law enforcement agencies. But the individual doctor has a role in defining the place of the first group.

One reason for our failure to hold the line against the marginal disciplines is that each doctor views with little concern the work of laymen in fields outside his own. An ophthalmologist may be disturbed at the expanding activities of the optometrist but he shrugs his shoulders at complaints about chiropodists. The roentgenologist calls for public education as to the functions of the commercially operated x-ray studio, but too many other doctors feel that the matter is of no interest to them.

Even an incomplete catalogue of the marginal disciplines which tend to overflow their banks, reveals an astonishingly varied list. There are optometrists, masseurs, commercial laboratories, and counter-prescribing druggists; there are lay administrators of unsupervised high colonic irrigations, chiropodists who treat club feet and dermatoses, amateur psychologists who glibly dispense psychiatric advice and enthusiastic first-aiders who

gallop to the scene of an accident prepared to insert a suture or set a fracture; not to mention operators of gymnasia who offer, for a small consideration, to put on weight or take it off, or who promise to build muscles or poise with equal confidence.

Against these practitioners the individual physician can do something. He can report their unauthorized activities to the State Board of Medical Examiners. He can realize, that whether or not it is his own ox which is gored, the problem is one that merits his attention. He can mount the platform and talk to the public on the scope of the marginal practitioners. Perhaps his greatest educational weapon is conversation with patients and lay friends. Thus, he should urge the friend or patient to "see an M.D. who specializes in eye diseases" rather than just "an eye doctor" (because the layman thinks of the optometrist as an "eye doctor"). Similarly he can ask, "Were these glasses prescribed by a physician or just by an optometrist?" The idea will sink in. He should indicate that he is sending the patient to a doctor who specializes in x-rays, not "to an x-ray man". When he wants a laboratory test, let him tell the patient, "I'm sending you to Dr. X, a physician who specializes in these tests," rather than "I'll send you to a laboratory." These marginal practitioners will rapidly fill any vacuum left by the M.D.'s own carelessness or indifference. Keeping the medical garden free of weeds requires eternal vigilance.

CHILD HEALTH STUDY

Half of the doctors in New Jersey who received the schedule of the Child Health Study have filled out the form and returned it. Which is a good proportion as questionnaires go. But the Academy of Pediatrics wants—and needs—a much better showing. It is discouraging to conclude that 50 per cent of New Jersey's doctors have simply thrown the schedule away without taking the few minutes needed to check the form. This is the kind of indifference which furnishes ammunition to those who charge that the medical profession is incapable of handling administrative projects. With the possible exception of a few geriatrists, every practitioner in New Jersey sees some children among his patients. The study therefore touches every doctor in the state. Many of the physicians who are loudest in their protests that the present system of medical care is adequate, are also the first to throw into the wastebasket any serious effort to determine the proof of this contention. Are the children of New Jersey receiving adequate medical care today? We think so . . . but we have no documentary evidence. This project of the Academy of Pediatrics is intended to collect the facts on which an honest determination may be made. To sabotage the study by ignoring the schedule that has been sent to you, is to give the critics of the profession a chance to point with scorn and say, "I told you so—doctors can't even cooperate with each other."

If you have received the schedule, fill it out and send it in. If you have already discarded your form you can get another from our Child Health Committee. Here is our chance to demonstrate that our index of cooperativeness is not 50 per cent or 75 per cent . . . but 100 per cent!

"TO LOOK UPON HIS OFFSPRING"

You once took an oath, and in it, referring to your brother practitioners you swore "to look upon his offspring upon the same footing as my own brothers".

Perhaps you never took it seriously—and no one indeed will hold you to it. Yet there is a way of putting that part of the Oath of Hippocrates into practice today. And in a thoroughly modern manner. That is by associating yourself with your professional brethren in that unique cooperative organization, the Society for the Relief of Widows and Orphans of Medical Men of New Jersey. Here is a genuine mutual help organization of a type fast disappearing. It has no agents, prints no eye-catching brochures, applies no high pressure. It goes quietly about its work, as it has every year since 1882, giving immediate financial aid to those who had been dependent on a doctor, giving dignified assistance to practitioners disabled through sickness or misfortune, and extending a helping hand to widows of physicians who have exhausted their resources. The cost to a member averages a dollar or two per death, depending on age. There are no salaries nor commissions. The prompt cash benefit provides a sum to help the widow over that depressed period when the estate is tied up and ready money sorely needed. Your membership will furnish aid to a professional brother in distress or to his family. Most technical trades and learned callings boast that they take care of their own people in distress. Should something less than that be said of the fraternity of physicians?

MEDICAL REPRESENTATIVE TO V. A. APPOINTED

Last month our House of Delegates proposed that an Executive Officer to The Medical Society be delegated for duty with Veterans Administration to inaugurate the new medical care plan, his salary to be paid by the Society. The contract evolved through meetings of the Special Committee of the Trustees of the Society and Veterans Administration made this proposal unnecessary as V. A. agreed to reimburse Medical Service Administration the salary of a medical representative.

The position of Medical Representative to Veterans Administration Regional Headquarters has been accepted by Dr. Edward T. Yorke. The position of Executive Officer to the Society is at yet not filled.

Dr. Yorke is an alumnus of Notre Dame in the class of 1930. He was graduated from Cornell University Medical College in 1934. After a two-year internship at Newark City Hospital he entered the medical department of Prudential Life Insurance Company in 1937 at their Home Office in Newark and has occupied this position to date except for time spent in military service.

Dr. Yorke entered active duty in the army in November, 1942. He served for 20 months as cardiologist at the Induction Station, Fort Jackson, South Carolina, when he was appointed chief medical examiner for the station. He later went to India as Chief of Medical Service at the 100th Station Hospital located at the Headquarters of the India-Burma Theatre.

Dr. Yorke, who resides in Linden, N. J., is a member of Union County Medical Society. He will take up his new duties on August 1, 1946, with offices at 37 Fulton Street, Newark.

With his background as a physician and administrator, Dr. Yorke is exceptionally well fitted to deal with the problem of medical care of the veteran to the best advantage of the veteran, the private physician and Veterans Administration.

Norman M. Scott, M.D.

ORIGINAL ARTICLES

NEUROPSYCHIATRIC PROBLEMS IN THE VETERAN AND HIS FAMILY *

By Joseph C. Yaskin, M.D., Philadelphia

Neuropsychiatric disability in the veteran is *our* problem. It is time for professional groups to assume the responsibility for all that this implies.

ORGANIC NEUROLOGIC DISTURBANCES

Organic neurologic disturbances include cranial trauma and injuries to the spinal cord and peripheral nerves. They are accompanied by motor disabilities, painful affections, and disturbances of sphincter control. In some cases, there are aphasias, convulsions and personality changes. These conditions differ from those seen in civilian life in two respects: first, the veterans' disabilities occurred in relatively early life; and second, they had special psychologic implications because of their occurrence under military conditions. With some notable exceptions, the disabled veteran and his family react in a manner not unlike that of the amputee, the blind and others physically disabled. Whether the disabilities result from injuries in military service, industry, transportation or home, they are accompanied by psychologic disturbances which often require special psychiatric care.

THE ROLE OF PERSONALITY

The structure and function of the individual's personality plays a major role in reaction to injury. But what is personality? It has been defined as the sum of all activities and reactions, physical and psychologic, in a given individual. It includes all traits, qualities, talents, interests, attitudes, habitual patterns and activities. Personality remains as a unit under all circumstances. When it reacts, it does so as a unit whether the stimulation comes from within or from without. The development of personality is, in part, determined by prenatal patterns and continues throughout the lifetime. Personality as a unit is constantly in flux, varying in effectiveness and control, with age, developmental crises and the constant influence of the environmental factors which include family, home, community, race, nationality, religion, industrial group and the rich "self".

Much of our thinking and acting and most of our feeling remain unconscious. We are unaware of most of our personality just as we are largely unaware of the activities of most of our viscera unless they become diseased. Because the reactions of a given individual depend upon the *type of personality,* it is advisable to define several of these types.

1. *Average Normal.* Here is the person who makes a satisfactory economic, social, marital and sexual adjustment, who performs efficiently without symptoms or marked emotional swings, who, most of the time, gets satisfaction from his life experiences and whose reactions to various stresses and strains are adequate and efficient.

2. *Neurotic Personality.* This is characterized by manifestations intermediate between normal character and traits of neurotic symptoms. In the neurotic personality the "neurosis is built into the character". The neurotic symptoms vary considerably with the type of neurosis, but there are some features more or less universal in all neurotic personalities. The basic psychopathologic process is one of anxiety or of its many modifications or substitutes. Hostility, overt or concealed, is often present. The neurotic traits always develop early in life, are modified by the many life experiences, usually manifest themselves by subtle attitudes and reactions, and become symptoms under the impact of appropriate precipitating causes.

3. *Syntonic Type (Cycloid, Extraverted).* This is characterized by swings of mood beyond those observed in the average normal.

* Read May 22, 1946, before Annual Meeting, The Medical Society of New Jersey.

These moods determine behavior in everyday activities. A syntonic personality is a predisposing cause of manic-depressive reactions.

4. *Schizoid Type (Shut-in, Introverted).* These individuals are characterized, on the one hand, by marked sensitiveness; and on the other, by unapproachable coldness. Regardless of the proportion of these qualities, the schizoid lives within himself. This type of personality is the soil from which dementia praecox develops.

5. *Paranoid Type.* This is characterized by the tendency of misinterpretation, abnormal suspicion, and stubbornness, and by consequent mood and behavior disturbances leading to poor adjustment. This is the soil from which paranoid reactions of various types develop.

6. *Rigid Type.* Here we have an overly serious, overconscientious, overmeticulous, strictly conventional, abnormally honest person preoccupied with problems of security and generally engrossed in immediate problems so that the future horizon is rather circumscribed.

7. *Constitutional Psychopathic Type.* This type of individual is neither insane nor intellectually deficient; but he lacks emotional and volitional stability, and "stick-to-itiveness", and does not benefit by experiences. He makes a poor economic, social and marital adjustment. Here are included pathologic liars and swindlers, the nomadic personalities, the antisocial individuals, some paranoid types and some sexual psychopaths.

ADJUSTMENT TO MILITARY LIFE

Regardless of the type of personality, most Americans (and those from other democracies) in military service had one common denominator. From a psychologic standpoint they were poorly prepared for the war. For over two decades, following World War I, young people were raised in an atmosphere of isolationism—an isolationism in which individual selfishness was fostered to the detriment of the needs of the country. It was a period of utterly false values in the economic, social and ethical spheres. These young people, reflecting their elders, were not prepared for the catastrophe which began in 1939 and is still raging in the making of the peace.

Upon induction into service, millions of young people entered a life of physical hardship, away from the shelter of home and community, mingling with others of different social, cultural and racial backgrounds. They had to meet obligations to the group; learn to depend on themselves and take commands; live with fear; learn to hate and kill—and at the same time remain an efficient unit of the organization and stay relatively free from internal conflicts.

REACTIONS TO MILITARY LIFE

The reaction to induction and military service varied with the individual. Fortunately, screening disqualified many. Less fortunately, constitutional psychopaths were accepted only to be discharged after varying lengths of service. They have since become burdens to the tax-payers and will be so for many years. Some, with neurotic personalities, found their place in the scheme of military organization. Others broke down early and were discharged. They developed symptoms such as anxiety, various conversion phenomena (lately dignified by the term "psychosomatic") and by irritability, insomnia and reactions which rendered them ineffectvie and maladjusted. Like all psychoneurotics who tend to attribute their symptoms to external factors, these men stress the hardships of military training as their major difficulty.

The men who developed major psychoses either in training or combat were those who had personalities predisposed to such breakdowns. Those who reached actual combat conditions or engaged in prolonged or perilous operational activities were, in the majority of cases, fairly stable individuals. Many of these men developed disabilities (called "combat fatigue") as a result of the hardships of war. Physical fatigue, long periods without sleep, poor diet, climatic hardships, prolonged strain with constant danger of death, contributed to breakdowns.

MORALE

Of equal importance in psychologic disturbances was the factor of lowered morale. Inadequate orientation in the meanings of the war

failed to answer such a major question as, "Why am I fighting?" The soldier was asked to hate and kill the enemy but he didn't know why. Many of them had come into the armed forces with their own anti-racial and anti-national prejudices. They found it difficult to despise these same characteristics and prejudices in the enemy. In addition, they received exaggerated news of strikes and fantastic stories of shipyard workers rolling in wealth. Such things as these obviously did not contribute to a good fighting spirit and brought forth one insistent demand: "I want to go home!"

Other factors contributing to lowered morale were frequent poor leadership, undemocratic privileges of officers, replacement of individuals with whom they had not trained and the common experience of the death or wounding of a buddy.

COMBAT FATIGUE

The so-called combat or operational fatigue varied in intensity from a mild tachychardia and tremors to devastating anxiety, insomnia, terrifying nightmares, fugues, many psychosomatic disturbances and less commonly, by withdrawal, depression, aggression and silliness. In these previously stable individuals, the threshold for stimuli was lowered and they reacted violently to external stimuli, dreams and pseudo-hallucinations. Most of the men, after varying periods of rest and treatment, made satisfactory recoveries; but some are now conditioned to a lasting lowering of the threshold for the trials and tribulations of life.

Many men, especially in the air service, developed a combat fatigue syndrome when on leave and prior to return to active duty. Others developed the same condition after discharge without disability, when they were confronted with difficult situations at home or in the community.

Even the veterans who did not suffer from any recorded combat fatigue, experienced enough to undergo many large personality changes.

CIVILIAN READJUSTMENT

The attitude of the individual returning veteran varies considerably. Most of them felt it their patriotic duty to serve and to sacrifice time and effort and even their lives for the good of all. Some, if not most, feel that those who were not in military service owe them a great deal. Beyond this, the attitude of the individual veteran depends a great deal on his pre-military personality and his reactions to his experiences or fantasies in the service. The average normal person will seek and hold a job without shirking or unnecessary fault finding. The psychopathic individual will continue to be a misfit. The psychoneurotic will exhibit anxiety and conversion symptoms, with additional elements of hostility and aggression which he justifies by his military experiences. In this respect he will attempt to work out his problems in much the same manner as does any psychoneurotic following insignificant trauma, which is the basis of a traumatic neurosis.

Those who suffered combat fatigue and who have developed a lower threshold to stress and strain may not complain but may experience difficulties in adjustment.

The young men who entered the service have, for the most part, evolved new ideas regarding security, education, ethics and social inter-relationships. However, they will find it difficult to adjust because little has been done to give them security or unravel their confusion. They are experiencing dislocations in their home life, developing bitterness about the housing problem and about the difficulties associated with obtaining veterans' benefits, the rapidly rising cost of living and the general attitude of selfishness, apathy and indifference from civilians, industrialists and politicians. In addition, there are the feelings of insecurity and unrest in conjunction with the beating of the drums for future wars, the threat of an atomic-bomb age and the failure to win the peace.

The problem of the returning veteran may be summarized by stating that he has internal tensions traceable to the combined effects of his personality make-up, the experiences of the war and the conflict and perplexities of the outside world as they affect him. In the majority

of cases he is an altered individual in a new world trying to find happiness and security.

THE VETERAN'S FAMILY

The veteran's family constitutes a large part of our population since hardly any one escaped having somebody in the service. Like those who went into service, civilians were unprepared for the catastrophe which unfolded itself in the last decade. They underwent the painful experience of seeing their dear ones depart and lived thereafter in continuous fear of the dangers of World War II, which proved to be devastating from the start. There were many economic and family dislocations, broken homes and betrothals, a tendency to overcompensate by excessive use of alcohol and other unfavorable activities. The fatigue and anxieties due to various causes have changed many individuals during the trying years of the war. It is not difficult to understand that many potential psychotics developed acute mental illness, that concealed neurotic trends became overt and that there developed disturbances of behavior traceable to war situations. The conditions of the war brought out latent trends which in the absence of war might have remained subclinical. It is of interest to note that many parents developed severe neuroses and often psychoses *after* the veteran returned unhurt from a prolonged stay overseas.

Many individuals whose relatives were killed in the course of military service suffered serious psychologic setbacks. Usually the reaction was grief, but in those predisposed, the death or maiming of the service man acted as an exciting cause for development of major psychiatric reactions.

At the end of the war, the civilian as well as the soldier emerged as an individual with a lower threshold for trials and tribulations, with considerable bewilderment regarding the various economic, social and family dislocations and with considerable perplexity regarding his present and future.

FUTURE TRENDS

The insecurities, perplexities and bewilderment of both the veteran and the civilian are not wholly psychiatric problems. If the public at large were willing to accept some psychiatric concepts, it would lead not only to a betterment of the population as a whole but indirectly to the beginning of trends preventing future wars.

The charter of the United Nations says: "Since wars begin in the minds of men, it is in the minds of men that the defenses of peace must be constructed." Many of our difficulties are traceable to disturbances of the unit of society which is the personality of the individual. Psychiatry may furnish a program of public mental hygiene, accomplishing a great deal in ameliorating various conditions even as medicine did in physical hygiene when it attacked contagious diseases and metabolic disturbances. The public must be educated to recognize psychiatry as a science of health rather than as a fad or as the central plot idea for the latest movie or novel. Much of this can be accomplished by efforts extending through grammar and high schools, into the colleges and continuing through various educational activities for many years therafter. To do so, there will be need for many more trained psychiatric personnel; but in the end it will not be uneconomical. The medical schools have already recognized the need for more intensive training in psychiatry during the four years of medical education and most Foundations are keenly aware of the need for additional psychiatric training.

During the war the common danger and hardships brought about unity and greater tolerance among diverse cultural, racial and religious groups. In the postwar period, however, there developed a recurrence of much intolerance, the sprouting of reactionary organizations with anti-racial and anti-religious bias, the breeding of resentments, hatreds and other evils which affect the economy and stability of the nation.

The recognition of these evils as they actually exist is the first step toward solution. Many veterans will attempt to solve their problems of insecurity and perplexity by returning to group activities which they found to be helpful in the Army or Navy. They will be easy

prey for reactionary organizations which are out to exploit, for sinister ends, the aggression and hostility of the returned veteran. On the other hand, veterans more fortunately guided will join established organizations such as the American Legion, their trade unions, progressive church groups and active Citizens' Committees through which they can find their greatest and healthiest expression.

The individual veteran or civilian who has personality disturbances or neurotic symptoms will require the aid of a psychiatrist. Veterans' clinics will be helpful and most of the general hospitals will have to establish a department of psychiatry to take care of the excess loads. The general practitioner will have to learn a great deal more about psychiatry (as did the internist) in order to handle individual problems.

The industrial executive and supervisor must learn to understand the problem of the returning veteran, the change in his personality, his lower threshold for stress and the many other problems that he has developed as a result of his experience in the military service. He must understand the veteran, like the traumatic neurotic, is trying to work out his tensions, anxieties, resentments and hostilities through the very symptoms which render him less effective.

SUMMARY AND CONCLUSIONS

The veteran and his family were psychologically unprepared for the change in the mode of living brought about by World War II. The war necessitated giving up their cherished individualism and subjected them to many physical, emotional and economic hardships. Their reactions to these hardships in the post-war period depend considerably on their pre-war personality make-ups and also on the severity of their war experiences. Their present attitudes and reactions vary but they all have in common a feeling of insecurity, perplexity and bewilderment regarding their present and future.

A successful adjustment of the various problems confronting the veteran and his family depends, on the one hand, on economic security, concerted educational efforts and improvement in inter-personal relationships, and on the other hand, on the psychiatric study and guidance of the individual. Psychiatry may be of considerable help in the problems of education, industrial relationships and many other phases of everyday activities. There will be need for increased psychiatric personnel and operational equipment as well as a greater understanding of the psychiatric aspects of illness by the practicing physician. The problem affects so many people that its importance cannot be overemphasized.

Graduate School, University of Pennsylvania

GLYCERINE JELLY BASE FOR PENICILLIN

Special advantages and superior action are obtained when penicillin is applied on a nongreasy glycerine jelly, according to a report by J. Spencer, E. J. Bishop and A. Ricks (*Lancet* 1:127, 1946). The jelly is made by gradually mixing 110 cc. of glycerine with 8 Gm. of powdered tragacanth in a dry mortar and pouring the mixture slowly into a jar containing 332 cc. of an 0.25 per cent solution of methyl-para-hydroxy-benzoate (Nipagin M). It is placed then in an autoclave and allowed to steam for ten minutes, after which it is sterilized at 10-pounds pressure for 30 minutes. When cool, 250,000 units of penicillin, dissolved in enough sterile distilled water (about 25 cc.), is added to make a total weight of 500 Gm. of jelly.

Spencer, Bishop and Ricks claim the following advantages for the jelly: (1) It infiltrates damaged and diseased tissue readily and easily; (2) the ingredients are readily and cheaply available; (3) the presence of glycerine, which is hygroscopic, has a dehydrating effect in inflammatory conditions and increases the penetrative action of the drugs held in solution; and, (4) it is easy to manipulate by spreading or pouring on skin lesions, wounds, sinuses or open cavities. The consistency of the jelly may be varied by regulating the amount of tragacanth.

THE IMPORTANCE OF RECTAL BLEEDING

J. Gerendasy, M.D., Elizabeth, N. J.

Rectal bleeding is a much neglected subject. It is the careless custom of many physicians to ascribe any rectal bleeding to hemorrhoids, often without even a simple digital examination. Attention has been repeatedy called to this dangerous attitude, especially as a potent cause of overlooking a malignant neoplasm in the sigmoid or rectum. There are a number of other ano-rectal conditions besides hemorrhoids and cancer which produce rectal bleeding (see the table), and some of these will be discussed briefly. However, the point to be stressed is that bleeding is one of the symptoms, above all others, which calls for a complete examination of the anus, rectum and sigmoid.

As indicated in the table, this discussion is limited to lesions within reach of the finger, the proctoscope or the sigmoidoscope. Bleeding beyond the reach of these instruments suggests other means of examination, especially the x-ray barium enema with the fluoroscope, double contrast and air injection technique.

As with other diagnostic instruments with practice comes understanding. The use of the proctoscope should be as routine as other aids to diagnosis, e. g., the auriscope or the ophthalmoscope.

The most frequent causes of rectal bleeding are hemorrhoids, anal fissure, rectal prolapse, polyps, the ulcerative disease of the terminal bowel and carcinoma.

The subject of hemorrhoids is so well known as to require merely calling attention to the necessity for visual examination. Internal hemorrhoids cannot be accurately diagnosed with the unaided finger; an anoscopic view is necessary. Again, hemorrhoids may be due to various causes, and it is by no means uncommon to find that the piles are merely an indication of a malignant growth higher up. Every patient of middle age or over should have a sigmoidoscopy to eliminate this possibility.

Prolapse of the rectal mucous membrane, polypi or hypertrophied papillae are sometimes mistaken for hemorrhoids. Proctoscopy is indicated.

Sigmoidal and rectal cancer can often be reached with the finger but sigmoidoscopy will give a much better concept of the tumor. Besides, biopsy is indicated in all suspected growths.

Anal fissure is comparatively easy to diagnose. There is little bleeding but excruciating pain with (or following) each bowel movement. Visualization of the lesion with a tag of hypertrophied skin presents a typical picture.

Rectal prolapse, more common in the young, is easily visualized on straining as a roseate of pink rectal mucous membrane. Proctoscopy is indicated to rule out a polyp or pin worms as a possible cause and to diagnose sigmoidal intussuception with bleeding as the only symptom.

A polyp is an adenomatous growth and may be pedunculated or sessile. It is potentially malignant and should be removed for histologic examination, especially at its base and the adjacent mucosa. A single polypus is more often found in the rectum and sigmoid than higher up in the colon. It is often the cause of obscure rectal bleeding. Proctosigmoidoscopy will assist in its detection.

The other major causes of rectal bleeding are the ulcerative diseases. Most important of these are chronic ulcerative colitis, lymphogranuloma venereum, amebic and bacillary dysentery.

Chronic ulcerative colitis should be the first thought in the presence of blood in the stool associated with loose frequent movements. It is not difficult to diagnose on proctoscopy as the appearance of the mucous membrane is characteristic. However, it is well to rule out routinely other causes of large bowel ulceration, particularly amebic and bacillary dysentery.

Sometimes operations are erroneously performed on these cases with serious, even fatal consequences. Sigmoidoscopy should be performed on all patients bleeding rectally.

Lymphogranuloma venereum may show

blood per anum but diagnosis is easy as the disease is usually confined to the rectum. The proctitis occurring in the presence of rectal stricture produces a dirty, thin bloody purulent discharge. The Frei test, either with mouse brain or chicken embryo antigen, differentiates it from other forms of proctitis.

Bacillary dysentery usually presents a picture of loose stools mixed with blood, pus and mucus. The sigmoidoscope reveals shallow ulcers somtimes difficult to differentiate from chronic ulcerative colitis. Diagnosis is confirmed by finding the specific organism in the stool culture the first week or two of the disease or later by specific agglutination reactions of the patient's serum.

CONCLUSION

The passage of blood per anum is an important symptom. It is the duty of the physician to make a differential diagnosis among the numerous conditions causing it. Digital examination and proctosigmoidoscopy are indicated in all cases and will assist in the diagnosis. A table of lesions often associated with ano-rectal bleeding follows:

TABLE OF LESIONS COMMONLY ASSOCIATED WITH BLEEDING

ANAL	RECTAL
Fissure	Proctitis
Ulcer	Prolapse
Piles	Cryptitis
Fistula in ano	Parasites
Wounds	Worms
Anal warts	Cancer
Condylomata	Cancroid
External thrombic pile	Lymphopathia venereum
Epithelioma	Intussuception of sigmoid into rectum
	Foreign body
	Impaction of stool
	Chronic ulcerative colitis

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IS EXERCISE A MYTH?

"A revolutionary statement about exercise recently made by Dr. Peter J. Steincrohn has startled the nation," an editorial by Morris Fishbein, M.D., says in the August issue of *Hygeia, The Health Magazine*. "His slogan is: 'Rest begins at 40.' Exercise, urges Dr. Steincrohn, is good for the development of muscle only up to that age; he says: 'Exercise all you want up to 30; slow up at 35; don't lift a finger unnecessarily after 40:' As far as golf is concerned, people after 40, according to Dr. Steincrohn, should play only if they like it and not with the idea that it is improving their health. His recommendation is that 'exercise after 40 be limited to gardening or walkng or both.' These views express the modern scientific attitude toward exercise for health after 40.

"The importance of exercise for the young person who is growing, or the man in training for the Army, or for any other supreme effort, is not questioned. Bear in mind, however, that being in training is not the normal condition of the average man.

"As part of the physical fitness program, innumerable experts are giving interviews in which they say that the nation can be made physically fit through exercise. Every advocate of a system has developed an outline of calisthenics in which all sorts of rubber and spring stretching devices, rowing machines, stationary bicycles, automatic horses and similar machinery are being promoted as ideal for the purpose. Such machinery is useful for those who cannot get outdoors and still must exercise, but for the man over 40 its value is problematic.

The more rapidly we expend our energy the shorter we are likely to live. The best advice has always been to keep exercise below the point of fatigue and exhaustion. This is the advice that is especially important for people past 40.

THE FITTING OF HEARING AIDS *

By Eva A. Thompson, Lieutenant (j. g.), U.S.N.R., Naval Hospital, Philadelphia

If a deafened individual is to be subjected to the nuisance and inconvenience of wearing a hearing aid it is essential that the instrument give him the optimum in sound discrimination. Few hard-of-hearing individuals have a true concept of their handicap; they will either minimize or exaggerate their difficulties. Ability to use their residual hearing to the best advantage is directly related to the extent that the deafness has produced psychological abnormalities. Normal hearing individuals have learned to ignore unimportant sounds while the man with a handicapping hearing loss has not been conscious of this noise. Ambient noise when first encountered by the use of a hearing aid is quite objectionable, necessitates a retraining period and unless the hearing aid is properly fitted adjustment may not be possible and the patient will eventually discard the instrument. Allowing him to make his own selection may result in his choosing an instrument with too little amplification and unsuitable frequency emphasis, therefore, it is of the utmost importance that careful guidance be given to prepare him for the acceptance of amplified sound. Patient cooperation must be obtained before successful hearing aid fitting can be achieved. For this reason the accurate testing and evaluation of hearing and hearing aid selection and fitting are important phases of aural rehabilitation.

AUDIOMETRIC APPARATUS

Only by means of modern electro-acoustic apparatus can thorough quantification of a patient's hearing loss be obtained. The audiometer gives an accurate picture of a patient's ability to hear discrete frequencies, determines whether the loss is equal for all frequencies, or is more severe in the upper or lower register. The speech evaluator determines the patient's actual ability to hear and understand speech. For hearing aid fitting this is of the utmost importance.

The speech reception test was first presented in 1942 by Hughson and Thompson. The Naval Unit in Philadelphia and the three Army Rehabilitation centers installed speech evaluators in specially constructed sound-proofed rooms. Basic electro-acoustic equipment consists of a mirrophone, amplifier, power supply, decibel (volume unit) meter, a loud-speaker and receiver. More elaborate apparatus such as an oscillator for producing discrete frequencies, a noise generator for testing speech reception in the presence of noise, a turntable and microphone for presenting recorded speech are included in the speech evaluators used in the Service Centers.

This apparatus is of high fidelity and is carefully calibrated. All test conditions are standardized. It is installed in two sound-treated rooms, one the test room and the other the operator's booth. The intensity of the test material, whether it be spoken voice (termed "live voice"), recorded speech, music, noise, or discrete frequencies reaching the patient's ear either through the loud-speaker or through the earphones, is accurately controlled by maintaining the decibel meter at a constant level and adjusting attenuators which control the output of the system. Unless this monitoring of the input is done properly, any tests carried out with the appartus will be inaccurate. Experience in the Army and Navy Acoustic Laboratories has proved conclusively that live speech or recorded speech may be used equally well, provided the input is properly monitored. The Naval Unit has preferred the live speech because (a) it allows more variability of test material, (b) the time factor is more flexible, (c) the necessity for renewing recordings is eliminated and (d) better rapport is maintained with the patient.

Loss for speech reception is in fairly close agreement with the audiometric average of the three speech frequencies (512, 1024, 2048 cycles) in approximately 85 per cent of the cases seen at the Rehabilitation Centers. Statistical material on a series of 898 cases at the

* Read before the Eye, Ear, Nose and Throat Section at the Annual Meeting of The Medical Society of New Jersey, May 22, 1946.

Naval Center shows a mean difference of 3.7 decibels, the speech reception loss being less than the audiometric average by this amount. Why, then, should the speech reception test be considered so important? There are two answers. First, this test gives psychologic information in regard to a patient's ability to use his residual hearing. Often it calls attention to the "psychogenic case"; second, it gives objective evidence of the actual gain in speech intelligibility obtained by the use of a hearing aid.

CRITERIA FOR HEARING AID FITTING

The goal of the hearing aid technician should be to fit the patient with the instrument that gives him the greatest gain in speech reception as tested under controlled conditions as well as being the most acceptable from every other point of view. No hearing aid is considered satisfactory unless it gives a gain of at least 30 decibels in speech reception, except where the hearing loss is so moderate that the patient does not need that much gain. In 147 cases studied statistically in the Naval Hospital on whom speech reception gain tests had been done the week before discharge, the average gain obtained by men who had been wearing their aids for approximately three weeks was 36 decibels and the maximum gain obtained by any man in the group was 61 decibels. Maximum gain in our total series (of 3200 cases) was 70 decibels. In all cases where the improvement in speech reception by the use of a hearing aid is abnormally high, the possibility that some psychogenic factor may be partly responsible for this gain must be recognized. Completely *normal* hearing can never be attained by the use of a hearing aid since only one ear is being used and difficulties such as localization of sounds, typical of the unilaterally deafened, are still present.

CONSTRUCTION OF THE AID

The modern vacuum-tube hearing aid consists of these basic parts: microphone (transmitter), amplifier, two or more midget vacuum tubes, condensers, resistors, and on-off switch, volume control, receiver and batteries. The receiver may be either an air conduction or bone conduction type. For air-conduction, a fitted earmold must be worn in the external canal; for bone conduction, the oscillator must be held firmly in contact with the mastoid bone by means of a headband. Two batteries are required: an "A" battery of 1½ volts and a "B" battery of from 22½ to 45 volts. With the exception of the receiver, all these parts may be incorporated into a single unit; or the batteries, microphone and amplifier may be encased in separate units. The instrument may have an adjustable tone control that changes the frequency emphasis or it may be built with fixed frequency characteristics. Minimum acceptable standards for performance and acoustic properties, such as amount and range of amplification and durability, have been set up by the Committee of Consultants on Audiometers and Hearing Aids of the Council on Physical Medicine of the American Medical Association. Only hearing aids which meet these standards have been used in the Navy's rehabilitation program. The test hearing aids are grouped into minimum-gain, moderate-gain and maximum gain instruments and the test aids for the individual case are selected from the appropriate group. Frequency emphasis suitable for the type of hearing loss is selected in a similar manner. Hearing aids made by nine companies have been used by the Navy as there is a difference in the tonal quality of these instruments. Because of this inherent difference, however slight, in the hearing aids of different companies and the number of different possible combinations of the basic parts, such as transmitter, receiver, tone control and battery voltage (the total possible combinations in the Navy's test instruments is over 1000), a satisfactory hearing aid can be found for almost every type and degree of hearing loss. Only six of the patients tested (in our series of 3200 cases) were so deafened that they could not benefit from the use of a hearing aid and training in its use.

PRELIMINARY STUDY OF PATIENT

No two patients are exactly alike and a thorough evaluation of both the medical and the psychologic aspects of the case should be made before attempting a hearing aid fitting. Each patient must be given a thorough physical and

otoscopic examination and a complete battery of hearing tests, in order to obtain accurate data in regard to his hearing loss. Medical information should include diagnosis and cause of deafness, duration, condition of the external canals and tympanic membranes, the presence or absence of vertigo, headaches or tinnitus, past history and family history. Such information is necessary for diagnosis. The cause of the deafness may determine the prognosis of the case, the duration may be indicative of the patient's tolerance for amplified sounds and the condition of the ear may be a contra-indication to the use of a hearing aid.

INDICATIONS FOR AN AID

When should a hard-of-hearing individual resort to the use of a hearing aid? Experience in the service programs has shown that a hearing loss of 30 to 35 decibels in the speech frequency range is a handicapping loss. Patients with this comparatively moderate loss can be successfully fitted with hearing aids. If the hearing loss cannot be corrected medically, the sooner the patient resorts to the use of the hearing aid the less likely he is to develop the negativistic attitude so typical of the deafened.

PREPARATION OF THE EARMOLD

A properly fitting, comfortable earmold is essential for satisfactory performance of an air conduction hearing aid. No so-called "universal" earmold is completely satisfactory and it is necessary to take the impression of the patient's ear with either plaster-of-paris or one of the newer acrylic materials. From this impression the earmold is fabricated. The Navy established a prosthetic laboratory for this phase of the work using a methyl methacrylate resin. Impressions taken with this material, if processed within the proper time (72 to 96 hours) are just as satisfactory as those done with plaster-of-paris. They can be taken more rapidly and the danger of the mold breaking on removal from the ear is eliminated. The process of taking the impression requires technical skill, but it does not necessarily have to be done by an otologist provided a proper otoscopic examination has revealed no contra-indication to the taking of the impression.

SELECTION OF THE EAR

The selection of the ear to be fitted with the hearing aid is a controversial question. The following basic rules were adopted in the Navy's Acoustic Laboratory. If there is an average moderate loss in both ears and the patient can still use the telephone satisfactory, the ear *not* used in telephoning is fitted. If there is a disparity between the ears (for example, an average loss in the better ear of 40 to 50 decibels and a loss of 70 or more decibels in the poorer ear), the ear with the better hearing is selected. Reason for this is that it would be necessary to use a powerful aid on the poorer ear to obtain the required gain of more than the 30 decibels difference between the two ears, and unless this is accomplished the patient still has a handicapping hearing loss. There are, of course, exceptions to these rules and special cases must be handled according to their needs.

SELECTION OF THE INSTRUMENT

The modern vacuum tube instruments are so superior to the old carbon instruments that only the former are used in the Navy's program. Bone conduction receivers are inherently less efficient than air conduction receivers in regard to amount of amplification and their ability to amplify high frequencies, so important in the understanding of speech. Most patients enjoy better reception with the air-conduction instruments; only 65 bone-conduction hearing aids have been recommended by the Navy. These 65 cases had either some contra-indication to the use of air-conduction (such as perforated tympanic membranes with profuse suppuration) or only a moderate loss of hearing due entirely to impairment in the conductive mechanism of the ear. Simple perforation of the tympanic membrane is not a contra-indication to the use of air-conduction provided the impression of the ear is carefully taken.

The actual selection of appropriate test hearing aids is done by first deciding the amount of amplification needed; next we determine whether this amplification should be equal for all frequencies, emphasize the high or the low frequencies or give equal amplification for all frequencies. The patient's tolerance for am-

plified sound must be considered and it has been found that preliminary training by means of a group hearing aid is beneficial in increasing tolerance. Preliminary screening tests are carried out and while no limit is placed on the number of hearing aids tried by the patient, an effort is made to avoid confusion by the use of too many test instruments. A comparative evaluation of the best two or three is then made by the speech reception test carried out both in quiet and in the presence of noise. The final selection of the aid is based on the results of this speech evaluation test plus the patient's subjective preference. It is a coöperative decision made by the patient and the technician.

AUDITORY TRAINING

Auditory training—training the patient in the use of his instrument—has proved of much value in helping him adjust to the use of amplified sound and is probably responsible for the large proportion of men who have gone through the Navy's Rehabilitation program and are still satisfied with their aids. A questionnaire sent to these men two months following discharge shows that 94 per cent are still using their hearing aids successfully.

CONCLUSION

Hearing aids are now socially acceptable prosthetic appliances. Though no simplified methods for fitting hearing aids have been developed by the Service Rehabilitation Programs, much knowledge has been gained with regard to the performance of these instruments, methods of fitting the aid to the hard-of-hearing patient and training the patient in the use of the aid. All of this knowledge can be applied to civilian practice and it is hoped that civilian hearing aid clinics patterned after the service units will be established in the near future.

DRUGS IN SURGICAL INFECTIONS

Drug administration in surgical infections may be prophylactic or therapeutic.

1. The prophylactic use of dugs is possible in war wounds, in contaminated accidental wounds of the soft parts, in compound fractures and burns in civilians and in operations on contaminated regions of the body, such as the alimentary canal.

2. In order to evaluate drugs properly in these cases there must be a comparison of drug treated cases with non-drug treated controls. These controls must alternate with treated cases without any selection of cases. This group presents a fixed starting point.

3. The appraisal of the therapeutic value of drugs in established surgical infections is much more difficult because there is no fixed starting point. The infection may have begun weeks, months or years before the drug treatment is started, during which time it may have had all kinds of treatment, any number of secondary contaminations, profound alterations in blood chemistry, in the nutritional status and in morale. It is difficult to run a parallel control series.

(a) In established infections the control may have to be the previous course of the case itself.

(b) However, if it can be shown that drug treatment obviates the necessity for surgery or makes possible a more conservative procedure or shortens the healing time or permits primary closure or early secondary closure which would not have been possible without the drug, its value may be demonstrated.

All these facts indicate the difficulty of evaluating drugs in the treatment of surgical infections. A carefully laid out plan should be followed and a number of different investigators in different cities should study the problem in a uniform manner, comparing and pooling their results.

Results of drug therapy in surgical infections may be designated by the terms (a) brilliant, (b) good, (c) questionable and (d) with no effect.

In the prophylactic studies, and in established infections when controls are used, the results in treated cases must be significantly better statistically than the controls before the benefit can be certainly attributed to drug treatment. When controls are not used the results must be repeatedly and consistently "brilliant" or "good" in a large series of cases before the benefit of drug treatment can be considered clearly proved.—Meleney, J. A. M. A., Vol. 124, No. 15, p. 1021.

MASSIVE DOSES OF VITAMIN D IN PEDIATRIC PRACTICE *

By I. J. Wolf, M.D., Paterson, N. J.

This is a report of five years' experience with single massive doses of vitamin D in pediatric practice. This method has a definite place in pediatric therapy. For example, the rapid healing of severe rickets induced by 600,000 units of vitamin D administered in one or two divided doses orally is just as dramatic as the prompt crisis initiated by sulfonamide therapy in pneumonia.

HISTORY

Vollmer in 1928 was the first to use massive doses of vitamin D experimentally in rats to protect them from developing rickets. During the next ten years numerous workers, principally in Germany, treated more than 160 cases of rickets and tetany with single doses of vitamin D ranging from 10,000 to 600,000 units with poor or rapid effect depending on the dose; lower doses gave ineffective healing, whereas higher doses gave prompt and permanent healing. In rickets following the use of 600,000 units of vitamin D, a marked clinical improvement was manifest in a few days. The serum calcium and phosphorus promptly resumed normal levels; healing of the rachitic process became apparent roentgenologically in about twelve days and was complete in about sixty days.

In 1938 Harnapp and others, also in Germany, began to use single massive doses of vitamin D for rickets prophylaxis. They found that if 400,000 to 600,000 units of vitamin D were given to normal or premature infants, effective protection against rickets for five winter months was possible. However, if fewer than 300,000 units of vitamin D was given, a full winter's protection could not be guaranteed, especially in prematures. The smaller dose had to be repeated during the winter months or the initial dose had to be higher.

In a recent study in wartime nurseries in England, Krestin[1] found that a single oral dose of 300,000 units of crystalline vitamin D_2 in oil was effective protection against rickets for six months. Among ninety-three infants, only three developed rickets as compared with 24 cases among 199 infants of the same ages receiving cod-liver oil.

In 1941 the author treated five cases of active rickets with 600,000 units of vitamin D orally. Healing was prompt and dramatic.[2]

In 1942, 62 infants were followed by roentgenogram, each of whom had received 600,000 units † of vitamin D, prophylactically in the form of electrically activated ergosterol once or twice during the course of the winter. No case of rickets deveoped.[3] In the following year, in a second series of 21 infants, a single dose of 600,000 units of vitamin D was found to assure effective prophylaxis against rickets.[4]

Another study** begun in September, 1944, was concluded in May, 1945. Its purpose was to determine whether 300,000 units of electrically activated ergosterol, rather than 600,000 units, was sufficient to protect an infant against rickets for a four-month winter period. Thirty-one infants in private practice were studied. One was colored; three were breast fed; most had had some form of daily vitamin D prophylaxis before the study was initiated. (See chart I.) The infants were examined monthly for clinical evidence of rickets. Infants under three months of age were given 50,000 or 100,000 units of vitamin D in a single dose at monthly intervals; after the third month, 300,000 units of vitamin D were administered in precooked cereal and milk in three divided successive doses. A second dose of 300,000 units of vitamin D was given again three or four months later. No other form of vitamin D was taken in the interim. New foods were introduced into the diet as follows: precooked cereals about the third month; soups and stewed fruits about the fifth month; puddings about the eighth month. No vitamin A was given except that available in natural form in the milk.

A roentgenogram ‡ was taken in April or May, four months after the last dose of 300,000 units of vitamin D. In no instance was any x-ray evidence of rickets found.

This study showed that 300,000 units of electrically activated ergosterol is apparently adequate to protect an infant for about three

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* Read at the Annual Meeting of the New Jersey Fellows of the Academy of Pediatrics, Jan. 30, 1946, Newark, N. J.

† Infron Pediatric, Nutrition Research Labooratories, Chicago, Ill. U. S. P. units referred to throughout.

** The clinical study reported herein was made possible through a grant by the Nutrition Research Laboratories, Chicago, Ill.

‡ Roentgenograms were taken by Dr. Jacob Roemer, Chief Roentgenologist, Barnert Memorial Hospital, Paterson, N. J.

1. Krestin, D.: Brit. Med. J., 1:78 (1945).
2. Wolf, I. J.: J. Med. Soc., N. J., 38:436 (1941).
3. Wolf, I. J.: J. Ped., 22:396 (1943).
4. Wolf, I. J.: J. Ped., 24:167 (1944).

winter months. For rickets prophylaxis an infant should receive at least four doses of 300,000 units each during the course of the year. Larger single doses of vitamin D insure better absorption and retention than smaller doses. Even on these doses a small proportion of infants develop flaring of the ribs which may indicate that the method is ineffective in preventing mild rickets although the roentgenograms are normal.

RATIONALE

Vitamin D is absorbed unchanged and circulates in the blood stream; it is stored in the tissues without inactivation; it may be metabolized and excreted in amounts depending on the dose administered; and it is better absorbed and stored if the dose is massive.

In laboratory animals, Heymann, in 1936, found detectable amounts of vitamin D circulating in the blood from two to three months after the administration of a single oral dose of 200,000 units of vitamin D. The vitamin was stored in the brain, erythrocytes, lungs, kidneys, liver, and blood plasma in ascending order of effectiveness. In adult human beings, Warkany found that after abrupt withdrawal of high daily doses of vitamin D, from three to six months elapsed before the concentration of vitamin D in the blood serum fell to a normal level (50 units per 100 cc. of serum).

MARGIN OF SAFETY

In administering large doses of vitamin D, there is considerable margin of safety, and the practitioner need not fear toxic effects unless excessively high levels are maintained for prolonged periods.

The delusion that large doses of vitamin D by itself might cause calcification of blood vessels or soft tissues has become firmly entrenched in the medical mind as the result of two series of events. First, in 1929, following the use of "vigantol" (a proprietary irradiated ergosterol), reports came out of Germany that this form of vitamin D was highly toxic and, in large amounts, even fatal. The exact doses used (in terms of vitamin D units) were not known, because this and similar preparations at that time differed not only in the potency of the irradiation product, but also in the concentration of vitamin D per cubic centimeter of the vehicle.

Subsequently, it became known that the toxic and antirachitic effects of different irradiated ergosterol solutions did not run parallel and that the irradiation of ergosterol for short period of time results chiefly in the production of tachysterol and calciferol, whereas overirradiation produced toxisterol (Substance 248) and suprasterols, lacking in antirachitic action but strongly toxic. The irradiation chain flowing out of ergosterol is:

Ergosterol to lumisterol to tachysterol to calciferol to substance 248 to the two suprasterols numbered I and II.

The old vigantol, according to the manufacturer's specifications, was required to be irradiated until toxisterol (not vitamin D) was produced in maximum concentrations.

Shelling and Jackson have pointed out that, "notwithstanding the fact that vigantol probably produced some toxic effects in human beings, it is equally true that many of the reports are groundless and the clinical and pathologic findings purporting to show its toxic effects are so slight and insignificant as to be in the realm of normal, or that they have no etiologic relation to vitamin D. For example, before the introduction of vitamin D, slight cellular infiltration of the wall of the kidney pelvis in a child suffering from chronic pyelitis would be looked upon as a natural and expected finding; yet as reports of toxicity of vigantol were forthcoming, such or similar findings assumed significance in the eyes of the investigators as signs of vitamin D poisoning."

Certain cases of "vitamin D poisoning," erroneously labeled, have been quoted repeatedly in the literature without any critical review of the original report by the reviewer. For example, Hatcher in 1931 and 1936 reported two cases of so-called "hyper-vitaminosis D," both in infants, in whom microscopic examination of the kidneys at postmortem showed a deposition of calcium within the tubules. One infant was a feeding problem from birth and the kidneys showed evidence of pyogenic infection.

Other cases in the literature in which vitamin D has been unjustly incriminated as the cause of metastatic calcification have been instances of severe renal disease, such as chronic interstitial nephritis, polycystic kidneys, hydronephrosis, or pyelonephritis. In such cases too small doses of vitamin D may lead to renal rickets, or, if larger doses of vitamin D are administered (doses which under

ordinary circumstances are perfectly safe), metastatic calcification of the organs and blood vessels may follow.

Experimental work in rats as well as clinical studies have shown the importance of renal damage on the toxicity of vitamin D.

Calcification of the arteries and organs may occur in infants as the result of disturbances of calcium metabolism in which vitamin D is not a factor. Kidney disease is usually present. Hild recently wrote of calcification of the arteries, and deposition of calcium in both lungs in an infant with renal insufficiency who received subminimal doses of vitamin D. Baggenstoss and Keith reported the case of an eight-week-old female infant who received no vitamin D and showed extensive calcification of the arteries, heart, and kidneys. He reviewed nine other similar cases from the literature, making no mention of vitamin D, in four of whom kidney disease was present.

A safe dosage of vitamin D therapy may be computed on the basis of body weight. In 1937 Steck, Deutsch, Reed and Struck showed that both animals and human beings can tolerate the administration of 20,000 units of vitamin D per kilogram per day for indefinite periods without intoxication. Higher levels for continued periods are toxic. Calcification of the kidneys is reversible if the vitamin is stopped.

A complete review of the subject of vitamin D toxicity in infancy is available in a previous communication.[5]

ADMINISTRATION

At least ten forms of vitamin D are known but only two have practical importance. One is activated ergosterol of plant origin, in its pure form known as *calciferol* or D_2, and given the name of "viosterol" by the Council on Pharmacy and Chemistry; the other is activated 7-dehydrocholesterol or D_3, of animal origin. The preparation used in these studies was *electrically* activiated ergosterol, also a form of D_2. This preparation comes in a capsule which has a potency of 100,000 units of vitamin D. The base consists of butter fat and lactose and the powder is freely miscible in milk, fruit juices or may be stirred into cereal or other foods. The preparation is tasteless. The vitamin is also available in peanut oil for intramuscular use but parenteral injection is required only in exceptional instances. This form of activated ergosterol is well tolerated and causes no ill effects in large single doses. The recommended doses will be outlined below. For the patient's protection *Non Repetatur* (N. R.) should be written on the prescription so that it cannot be refilled without the physician's knowledge.

DIAGNOSIS

Authorities have stressed the unreliability of diagnosing mild rickets clinically. A suggestion of beading or prominence of the frontal bosses is no definite indication of rickets. For diagnosis, the practitioner needs roentgenograms of the growing ends of the bones, particularly the ulna and radius. The development of flaring and occasionally funnelling of the chest has been observed and although it might be attributed to the inadequacies of the method, this is not true in every instance. Congenital larygeal stridor, which is fairly common and causes varying degrees of respiratory obstruction, may produce funnelling and flaring. Nonrachitic flaring of the ribs may develop in infants with large abdomens.

OTHER VITAMINS

The question of the addition of other vitamins to the diet is often asked. An adequate amount of vitamin A (1000 to 2000 units) is present normally in milk. This is not altered by evaporating or irradiating the milk. No vitamin A deficiency in infants will develop on this level. The vitamin B complex is introduced into the diet with the addition of cereals and other foods. Vitamin C, however, must be added.

THE MASSIVE DOSE TECHNIC

1. *Treatment of rickets.* Six hundred thousand units orally or parenterally in a single dose, or in two divided doses, on successive days.

2. *Treatment of tetany.* This same dosage

5. Wolf, I. J.: J. Ped., 22:707 (1943).

cures tetany by rapid elevation of the blood calcium.

3. *Prevention of rickets.* If parents are well educated and cooperative, the routine consists of 300,000 units every three months or 600,000 units every four months. Among the uneducated or uncooperative, it is best to give 600,000 units orally or parenterally once or twice during the winter months. In hospital practice, the program consists in the administration of 100,000 units for all pediatric admissions (except renal cases). The dose is repeated monthly if patients remain in the hospital for prolonged periods. In war-torn areas, as part of a program of rehabilitation, the dose of 600,000 units should be used for prevention or treatment of rickets.

4. *Other applications*—as follows: (a) Older children—simplicity recommends itself—monthly or twice during winter. (b) Dental caries—incidence found less on massive doses of D (Brodsky, Schick and Vollmer, 1941). (c) Refractory rickets: large daily doses required for healing. (d) Prematures require larger doses of vitamin D. (e) Vomiting babies. Their daily absorption is unpredictable but massive doses are usually well tolerated. (f) Allergic infants. Give single doses to avoid sensitization. (g) Chronic intestinal indigestion, celiac disease and congenital cystic fibrosis of pancreas: intramuscular administration of 600,000 units.

SUMMARY

The massive dose method of vitamin D therapy offers the pediatrician an additional implement for preventing and treating rickets. It produces rapid and effective healing in ordinary rickets; in refractory rickets there is no alternative but to use daily massive doses. Under special circumstances, such as in war-devastated areas, among uneducated groups and in hospital practice, the single dose method of rickets prophylaxis and treatment is ideal.

In a recent study (1944-45) 31 infants were given 300,000 units of electrically activated vitamin D at three to four-month intervals during the winter. Roentgenograms taken in the spring, four months after the last dose, disclosed not a single case of rickets.

A series of charts appears in the author's reprints.

231 E. 31st St.

VITAMIN E AND HEART DISEASE

An editorial appearing in *The Journal of the American Medical Association* challenges the reported miraculous powers of vitamin E in heart disease and states that "far too often of late there has been overemphasis in the popular press on research too fresh from the laboratory and too inadequate as to evidence to permit evaluation."

The Journal article says:

"Announcement in newspapers and particularly in *Time* that large doses of vitamin E will bring relief from all common forms of heart disease once again prompts discussion of the manner in which the results of medical research should be brought to the attention of the public. Far too often of late there has been overemphasis in the popular press on research too fresh from the laboratory and too inadequate as to evidence to permit evaluation. The reported discovery of new and almost miraculous powers of vitamin E needs careful evaluation and confirmation because the substance had already been investigated by many competent clinicians and found wanting. Nothing in the known pharmacologic actions of vitamin E would lead one to suspect either a vasodilating action, a myotonic effect or an ability to repair damaged heart muscle in human beings."

DIARRHEA IN AN ARMY GENERAL HOSPITAL *

By Manfred Kraemer, M.D.,† Newark, N. J.

Although reports have appeared in the lay press and in medical journals regarding the danger of the spread of parasitic disorders by returning soldiers, many so-called "tropical diseases" are endemic to New Jersey[1,2]

Marion[3] examined the stools of 1000 unselected military returnees from overseas service and found Entameba histolytica in the stools of 16.8 per cent. This incidence does not appear high, and indeed Marion concludes the rate of amebiasis in returning service personnel is no higher than in many surveys conducted on the civilian population in the United States.

Belding,[4] before the war, found the incidence of infestation of the American public with various parasites to be: Entameba histolytica, 10 per cent; Entameba coli, 30 per cent, and Entolimax nana, 14 per cent.

This paper reports the stool findings in patients of the 188th General Hospital in England who had, or in the course of their stay at the hospital developed, diarrhea.

Patients admitted to general hospitals primarily for diarrheal disorders were adequately studied. Most admissions, however, were for non-diarrheal diseases and patients who developed bowel looseness in the hospital were usually treated symptomatically for their diarrhea, no effort being made to investigate etiologically or treat definitely these sporadic diarrheas. Most of our patients were admitted for battle wounds. If such a patient with, let us say, a fractured femur, on ward rounds complained of diarrhea, the ward surgeon usually ordered a mixture containing bismuth and paregoric. The diarrhea ceased and the condition was forgotten. The case was not even included among the reportable diseases as a common diarrhea. These sporadic cases which responded readily to bismuth and opium may have been instances of food poisoning or paratyphoid, bacillary or amebic dysentery. By treating the diarrhea symptomatically the causal agent was not eradicated. Nothing was accomplished from a public health point of view in preventing contact cases and the patient was likely to suffer a relapse after leaving the hospital. The ward surgeon often concluded that the diarrhea was a manifestation of anxiety.

With particular reference to discovering cases of endemic amebic dysentery a program was finally adopted for the handling of all sporadic cases of diarrhea. This routine is a procedure which should be adopted in civilian hospitals. Almost all of the specimens referred to in this study were submitted to the laboratory ‡ because a patient complained of bowel looseness.

The value of these examinations to the clinician depends on: (1) the care taken in the collection of the specimen, (2) the number of specimens examined, and (3) the skill of the examiner.

ROUTINE FOR STOOL EXAMINATIONS

The 30 per cent incidence of commensal parasitism in the United Stataes was used as a basis to test the efficacy of stool examinations. If a laboratory does not report some kind of parasites in at least 15 per cent of the patients examined, the method of examining and collecting stools must be reviewed. In our hospital 20 per cent of all patient's stools showed some form of parasitism, a figure which might have been higher if expert personnel had been available at all times. We found the following procedure helpful; it should be strictly observed and may be considered as a minimum requirement for adequate diagnosis:

1. *Number of specimens per patient:* A stool examination should mean study of at least three specimens. The nurse should prepare the

* Read before the Section on Gastro-enterology and Proctology of the Annual Meeting of The Medical Society of New Jersey, May 22, 1946.

† From the Presbyterian Hospital in Newark, N. J.

‡ Stool studies were performed under supervision of Major C. H. Boissevain.

1. Asher, M., and Kraemer, M.: Amebiasis in Northern New Jersey. Am. Jr. Med. Sc. 186:409 (Sept.) 1933.
2. Kraemer, M., and Asher, M.: Amebic Dysentery and the General Practitioner in New Jersey. Jr. Med. Soc. N. J. 31:469 (Aug.) 1934.
3. Marion, D. F., and Sweetair, F. N.: Amebiases in Military Overseas Returnees. Ann. Int. Med., 24:2, 186 (Feb.) 1946.
4. Belding, D. L.: Textbook of Clinical Parasitology. D. Appleton-Century Co., Inc., 1942. Page 82.

laboratory request slips for three specimens. If symptoms persist and no explanation for diarrhea is found, six specimens should be examined before ruling out parasites. If protozoa of commensal species are found in one of the three specimens submitted, this is evidence that the patient's food or fluid intake has at some time been contaminated by feces and a search for at least three additional specimens should be made to rule out a disease producing protozoan. Of 22 cases infested by Entameba histolytica, 17 were found in the first specimen submitted, three in the second, one in the fifth and one in the eighth. Entameba coli or Trichomonas hominis may be found in the first specimen while subsequent examinations disclose the presence of Entameba histolytica. Doctors, even in the army, remained individualists and it was very difficult to make them observe this routine and convince them of the necessity of ordering an adequate number of stool examinations. Our figures show an average of only two specimens examined per patient; it should have been higher.

2. *Method of collection:* The patient was instructed to go to the laboratory when he had a desire to defecate and to move his bowels there. At the laboratory he was given a sputum cup into which a specimen was passed. The patient was instructed to pass the first inch of stool into the toilet bowl and collect a portion of what was passed later. It is not necessary to use saline laxatives to insure adequacy or fluidity of specimens. Patients who could not walk to the laboratory were taken in a wheel chair. Only for those few patients who could not be moved in a wheel chair were specimens taken to the laboratory.

Ward attendants were instructed to give these bed patients a warmed bed pan; to stay with the patient while the stool was being passed; to instruct the patient not to pass the urine into the pan and to discard toilet paper into another receptacle. The ward attendant immediately took the stool to the laboratory and handed it to the technician. He was not permitted to place it on a specimen shelf or in an "In" basket. He did not transfer the stool from the bed pan. Any intermediary handling or transfer of stool results in cooling and prevents the finding of trophozoites. Laboratory request slips for stool examinations, previously filled in, were kept in possession of the *patient* at all times so that there was no delay in obtaining them when the stool was passed. This avoided the complaint: "I passed the specimen but the laboratory would not take it as I had no slip." Specimens were never lost in the ward latrines as they were never passed there. Specimens never had a chance to cool. There was no chance of a ward attendant substituting his own specimen for one that was lost. There was no chance of a malingering patient substituting the specimen of another patient for his own.

Nurses were instructed to order, without consulting a physician, immediate stool examinations and bacterial examinations of vomitus in acute gastro-intestinal upsets such as occur in epidemic acute food poisoning. Patients affected by such an epidemic usually get well quickly and have only one or two loose bowel movements, and one attack of vomiting. These specimens are too often disposed of before a physician has an opportunity to see the patient.

The finding of staphylococcus or bacillus proteus in the vomitus may aid in determining the source of food poisoning and in preventing future outbreaks.

3. *Examination at the laboratory.* The fresh specimen should be examined promptly on the warm stage microscope. A warm stage was essential in the English climate and was improvised by Major Boissevain. He enclosed the microscope in a wooden box containing a light bulb for heating, leaving apertures for the eye piece and for manipulating the objectives and mechanical stage. Care was exercised not to overheat the stage. It is best to mix a droplet of stool with a drop or two of warm physiologic saline for this examination. After the microscopic examination of the warm fresh specimen was complete, smears stained with D'Antoni's Iodine were examined. Search with low and high power for suggestions of protozoa or cysts always preceded identification by oil immersion. With training, most protozoa can be identified by high dry lens. The use of oil immersion in fresh or Lugol's stained specimens may result in pushing the cyst or proto-

zoon out of the field. It takes considerable skill with the use of the fine focus adjustment to change from high dry to oil and catch mobile parasites in the field. If cysts or protozoa were seen, smears were stained by Heidenhain's hematoxylin method for later identification and purposes of record. Zinc sulfate flotations were made routinely of every specimen for concentration of ova and cysts. Due to changes in osmotic pressure the zinc sulfate solution distorts the appearance of the cyst.

If the specimen was microscopically not remarkable or if acute food poisoning was suspected a culture was made on SS Medium and on EMB Agar. Enrichments were made in Selenite F Broth or Tetrathionate Broth. In the epidemics of mild gastroenteritis in our hospital no specific organisms were found in the stools, unless the presence of a large number of B proteus may be considered as such. In stool cultures of 206 patients with sporadic diarrheas, Salmonella were found in four. Shigella were isolated from two.

4. *Diet and Medication.* As soon as a patient reported a diarrhea he was placed on a diet consisting only of tea and sugar (no milk) for 36 hours. Diarrheas due to food idiosyncracy and most food poisoning are self limiting. The tea and sugar diet avoided reintroduction of the offending agent, supplied needed fluid and put the bowel at rest. No medication was prescribed except that .0006 gram of atropine sulphate was given by mouth for severe cramp. Bismuth preparations were not used. By avoiding an admixture of bismuth, microscopy of the stool is easier and good growth of culture is more likely to result. By avoiding opiates an adequate number of stool specimens is assured for examination purposes.

5. *Training of laboratory personnel* is essential for the proper functioning of this program. Extensive experience with intestinal protozoa has convinced me that diagnostic failures result chiefly from inadequately trained and disinterested technicians. The teacher and technician must jointly examine stools until the technician has become familiar with the common protozoa, cysts and ova. Lectures do not make a microscopist. A collection of specimens, stained or otherwise, is helpful but expertness will come only from the tedious examinations of many fresh specimens.

The interest of the technician can be roused if the clinician is called to the laboratory to see all positive specimens. The enthusiasm of clinician and pathologist is quickly imparted to a student technician and stool microscopy becomes fascinating to him. Inadequate training of laboratory personnel in stool microscopy has been noted not only in military installations but in civilian institutions—even those with university affiliations. Most graduates in medical technology are poor stool microscopists. Insufficient emphasis is placed on this subject in most laboratory schools. In civilian practice I have found it more practical to train a stool microscopist than to attempt to find one.

The technician who made most of our examinations had never used a microscope prior to his induction. A combination of youth and enthusiasm resulted in a technician who, after several months, excelled his teachers in ability to pick protozoa out of the stool.

RESULTS

The accompanying tables show the results of 732 stool examinations on 368 patients. With the use of this routine we were able to pick up 22 cases of amebic dysentery, almost all of which were admitted for causes other than diarrhea (mostly for battle wounds). Had these patients received the usual bismuth and paragoric treatment their symptoms would have cleared temporarily and their amebic infestations would not have been recognized. Treatment with a combination of emetine hydrochloride and chiniofon or carbarsone was successful in all of our cases. The 14 cases of giardiasis were treated with atabrine but whether the giardia caused the diarrhea is problematic.

The cases of amebic dysentery had not come from areas of epidemicity. It was assumed that these patients had been carriers but that some break in resistance of the host, due to exposure or severe wounding and concomitant shock caused a breakdown in the resistance of the host or stimulated excystment of the protozoön.

CONCLUSIONS

1. Sporadic cases of diarrhea occurring in hospitals may be due to intestinal protozoa.

2. Adequate stool examinations with the technic described should be performed on all cases of diarrhea.

3. The incidence of intestinal protozoa in soldiers is approximately the same as in the general population of the United States.

4. The drugs available are adequate for treating amebic and giardial dysentery.

TABLE 1

Feces Examination, 188th General Hospital
12 June 1944 to 9 April 1945

Examinations	732
Patients	368
Number of patients having protozoa in feces	76
Average examinations per patient	2
Per cent having protozoa in feces	20%
Number of patients having Ova in feces	11

Bacteriologic Examinations

222 cases with 249 examinations

Salmonella species	4
Shigella paradysenteriae	2

TABLE 2

Species of Parasites Found	Patients
Entameba histolytica	22
Entameba coli	30
Iodameba buetschlii	10
Entolimax nana	25
Giardia lamblia	14
Trichomonas hominis	12
Hookworm	9
Trichocephalus trichiurus	2
Enteromonas hominis	2
Hymenolepis nana	1

27 patients had more than one species of protozoön present. Nine of these had E. histolytica.

234 Roseville Ave.

MASKED GOUT

Gout, which is characterized by painful attacks in the joints, too often assumes a false identity by exhibiting symptoms common to other diseases such as bursitis or rheumatoid arthritis, according to *The Journal of the American Medical Association.*

Joseph P. McCracken, Philip S. Owen and Joseph H. Pratt made a detailed analysis of 100 cases of gout previously unreported.

Ninety-three of the patients had acute gout. The remaining seven suffered from chronic gout. This term is given to those cases in which persistent deformity or rigidity of the joints occurs. In 32 of the patients gout had existed five years or more before the diagnosis was made, in 20 patients 10 years or more, in 14 patients 15 years or more, in eight patients 20 years or more and in two patients 30 years or more.

Gout symptoms begin with painful attacks involving the joints, most often the foot or toe. The affected joint becomes red, hot, tender and swollen. Fever follows with an increase in the white cells of the blood. These signs seem to indicate infection which the gouty patient actually does not have. The attack, lasting days or weeks, eventually ends, leaving the patient completely well until the next attack which may be years later.

Colchicum brought rapid relief to 37 of 44 treated patients with acute attacks of gout. This drug controls pain and cuts short attacks of gout. The authors noted that pain was abolished in from 12 to 24 hours after the first dose was given.

Overeating, overdrinking, injury or a surgical operation may bring on an attack to a person susceptible to gout by heredity. Repeated attacks of gout result in uric acid deposits in the joints causing bone destruction and a deforming type of degenerative joint disease.

Of the group under investigation by the authors, 91 were men and nine were women. Arranged by decades, the patients' ages varied: from 19 to 30 years 14 patients, 31 to 40 years 21 patients, 41 to 50 years 30 patients, 51 to 60 years 28 patients and 61 to 73 years seven patients.

PREOPERATIVE AND POSTOPERATIVE CARE OF THE DIABETIC *

By William Nyiri, M.D., Newark, N. J.

Diabetes with surgical complications may be subdivided into three groups: (1) elective operations; (2) surgical emergencies; (3) patients with certain infections and with dys- or hyperthyroidism.

ELECTIVE OPERATIONS

In this first group, surgical treatment may be postponed until the physician has time to bring the diabetic state under as good a control as modern facilities allow. The essential aim is to have the patient's carbohydrate equilibrium under control, to have his acid-base balance normal and to have his glycogen depots filled up. After accomplishing this goal, the only difference preoperatively between a diabetic and a non-diabetic lies in the precaution not to leave the diabetic under carbohydrate starvation overnight or for many hours prior to surgery. In view of the frequent desire to keep the stomach empty preoperatively, this is best carried out by intravenous administration of 500 to 1000 cc. of 5 per cent glucose in physiologic salt solution. Insulin may be added directly to the infusion fluid or given hypodermically. The latter route is preferable because it permits greater flexibility of dosage, according to varying needs. In severe operations which require much time, intravenous glucose may be repeated during the operation. Postoperative diabetic management depends on the severity of the case and the limitations set by the surgeon. Patients who, from the surgical standpoint, have no restrictions on the gastro-intestinal tract may soon be returned to the diet and possibly insulin dosage which they followed before the surgical complication. Patients who, for the first few days postoperatively are not to eat or even drink must receive their carbohydrates in form of intravenous clyses of 5 per cent glucose with saline. The quantity and succession of these infusions as well as the amount of insulin to be administered depend on the severity of the diabetes and the state of the water metabolism. We rely chiefly upon the symptom of glycosuria to determine these criteria. In most cases, examination of the urine four to five times a day is sufficient (without burdening the attending personnel unduly) to reach the proper decisions and make adjustments in the treatment. If spontaneous voiding is impossible, occasional catheterization may be necessary. In acidosis and in very severe glycosuria in which proper treatment may depend on changes made every one to two hours, the doctor may need the urinary information more frequently and will proceed accordingly. The plasma acetone test, which can be done in a few seconds, is more reliable than ketonuria to distinguish between severe and milder acidosis; it even permits an adequate judgment in the rather rare cases where ketonaemia but no ketonuria is present due to "kidney shut-down". As the patient progresses to the stage where food intake becomes permissible, parenteral measures are gradually replaced by oral feeding; here one starts with the carbohydrates as liquids and step by step adds starches in semisolid and solid forms. Loss of protein, caused by these restrictions, is not serious enough to warrant concern; the protein administration is only of secondary consideration for the time being. For obvious reasons, fats have no place in the treatment.

Many physicians like to give a basic dose of the insulins with prolonged effect and use the unmodified insulin as supplement when necessary. Our group at the Newark City Hospital prefers the almost exclusive use of regular insulin because of its action of short duration. Frequent smaller doses allow more flexibility in the management of cases and help prevent insulin reactions. These reactions are at least as damaging to the postoperative course as are acidosis and dehydration. We consider the unmodified insulin safer, particularly in cases not previously studied or in patients known to be difficult to keep under stable control.

* Presented at the Academy of Medicine of Northern New Jersey on October 26, 1944.

SURGICAL EMERGENCIES

With surgical emergencies, no time should be lost ,no matter how severe and complicated the metabolic disturbance. It is for the surgeon to say whether a surgical emergency exists in a given case. The operation should take place without delay if waiting would only render the outlook gloomier. On the other hand, the diabetic (antiketogenic) treatment may start simultaneously and at once without interfering with the surgeon. The intravenous route, essentially according to the plan described above, should be used. Unless too much time was lost previously, the patient's acidosis or lack of control will be sufficiently improved within a comparatively small span of time (several hours) to improve postoperative chances of complete recovery. Of course, in such emergencies the risks are greater and the physician will usually have to resort to more drastic insulin dosage.

INFECTIONS

The third group, which comprises infections, like abscesses, phlegmons, infected gangrene, cholecystitis, appendicitis, infected urinary tracts, osteomyelitis, etc., stands between the first two classes. Here the infection, with its often trypsin-like toxic effect, will have a detrimental influence on the diabetic state. Insulin resistance, fever and general toxicity will stand in the way of efficacious metabolic treatment. Therefore, speedy surgery is the first step in the metabolic therapy. Sometimes improvement of the carbohydrate tolerance after opening and drainage of the infected focus is so dramatic that it allows a quick, drastic reduction of the amount of insulin. Then our only fear in diabetic treatment is insulin overdosage. Diabetes with dys-, and hyperthyroidism may be included in this third classification. The excessive amount of thyroxin and lack of insulin in the human body represent a dangerous metabolic combination. Here again as in infections, speedy operation is in order. This quickly allows, indeed often necessitates, substantial diminution in insulin dosage. The preoperative use of thiouracil offers the same advantage in diabetics as in non-diabetics.

BLOOD SUGAR LEVEL

Many surgeons hesitate to operate on a diabetic unless fasting blood sugar is within normal limits. Generally speaking, many diabetics have a blood sugar curve which is fairly leveled throughout the twenty-four hours of the day and which does not change easily no matter what complicating factors arise. But there is also a not too small group of patients, whose blood sugar curve fluctuates within wide margins so that the least complicating influence will increase the preëxisting variability. The latter tendency is more common among diabetics in the "intellectual" stratum of the population. Blood sugar, therefore, will not always give a true picture of the severity and extent of the metabolic disturbance. The basic derangement in diabetes mellitus is admittedly the loss of carbohydrates through glycosuria, followed by the changes in salt, water and fat metabolism. By administering enough insulin and carbohydrates, one can insure in practically all cases, utilization of a sufficient amount of glucose. The overflow, which then still manifests itself as hyperglycemia and glycosuria will not exercise any appreciable influence on the course of events. For obvious reasons only excessive hyperglycemia and hypoglycemia will serve as warning signals. The healing tendency is not materially influenced by hyperglycemia; this thought has been accepted by most members of our profession. Whoever still has doubt about it, is reminded of the modern surgical practice of giving continuous intravenous glucose infusions pre- and postoperatively in non-diabetics, whereby the blood sugar is kept on higher levels for days, because under the circumstances of sugar influx into the blood stream even the healthiest pancreatic gland can not produce insulin fast enough to keep the blood sugar within normal limits.

Another important point is the matter of water metabolism in surgical diabetes. The amount of the intravenous infusion fluid varies greatly with the individual clinician. Obviously it will depend on the degree of dehydration of the patient and it is impossible to follow any fixed rule. However, it may be wise not to introduce excessive amounts of water as the already weakened circulation may be overtaxed.

Other things being equal, the optimum quantity of intravenous fluid in twenty-four hours is 3000 cc. In a 5 per cent glucose solution this introduces 150 grams of dextrose. Even making allowances for a sizable glycosuria, this still permits the utilization of ample carbohydrates.

FATS

Just as each diabetic has his individual blood sugar fluctuations, so the readiness or disinclination to go into acidosis is an individual matter. Some diabetics may go off the proper prescribed diet for a long time and indulge in fats without showing ketogenic tendencies. Others are indiscrete only once and clinical and chemical acidosis set in without delay. For this reason a surgical diabetic, especially when not previously known, is better off without any fats; especially as caloric calculations do not have any place for the time being. Therefore, it is our practice to bar fats completely from the pre- and postoperative management of diabetics.

CONCLUSION

Though insulin makes surgery in diabetes far safer than ever before, the surgical mortality rates are still higher in diabetics than in non-diabetics. Roughly 7 per cent is the rate for "prepared" and as high as 20 per cent for "unprepared" diabetics. These figures teach us that the physician has to be in attendance pre- and postoperatively without interruption and that our diabetics have to be constantly warned to keep themselves under good control in order to be "prepared" for any unexpected surgical or medical complications.

LARGE DOSES OF VITAMIN D MAY CAUSE DEATH BY CALCIFYING TISSUES

Vitamin D in massive doses may cause death. It produces cell injury followed by calcium deposition, according to two physicians who report the case of the only female adult known to have died as the result of this calcifying action.

Writing in the April 27 issue of *The Journal of the American Medical Association,* Bauer and Freyberg say that "In the human being death may occur, even in the adult, as a result of vitamin D intoxication causing calcification of organs and arteries."

Metastatic calcification results from the deposition of lime salts in a tissue or part at the same time that marked decalcification of the bones is taking place. Most previously reported cases were boy infants from 4 to 18 months old. The vitamin D preparations given to them had included simple fortified cod liver oil, ultraviolet irradiated ergosterol which comes in a crystalline form and electrically activated vaporized ergosterol.

The kidney seems to be the most vulnerable of any tissue to the calcifying action of vitamin D. However, the lungs, stomach, arterial vascular system and myocardium or heart muscle are also involved.

Citing the work of other investigators, the authors point out that the "factors which influence the toxicity of vitamin D are the dose per unit of body weight, the route and duration of administration, the composition of the diet in regard to the mineral and organic contents, the state of the alimentary tract, species susceptibility, age, preexisting pathologic conditions, the vehicle in which the vitamin is administered, the state of the endocrine system, the purity of the vitamin preparation, the source of the vitamin and other factors not yet recognized."

In recent years large doses of vitamin D preparations have been prescribed for the treatment of a wide variety of diseases, including arthritis, hay fever, vitamin D deficiency, psoriasis, a skin disease, acne, and trichonosis, a disease of the hair.

In conclusion Bauer and Freyberg say: "It is regrettable that . . . these potentially toxic preparations . . . have been sold to the public without need for prescription."

NOTE: For another opinion on this subject, see page 322 of this JOURNAL.

Jour. Med. Soc. N. J.
Aug., 1946

RECENT ADVANCES IN OCULAR THERAPY *

Irving H. Leopold, M.D., Philadelphia

Ophthalmology has shared in the progress made during the last several years in the development of anti-infectious and anti-biotic drugs. However, before it can be assumed that any of these preparations can control ocular infection, two conditions must be fulfilled:

1. The organism responsible for the ocular infection must be susceptible to the drug.

2. The drug must be able to reach the responsible organism in effective concentration.

Investigators interested in the ophthalmologic applications of these agents have concerned themselves therefore with four main problems:

1. The concentrations of each drug obtained in the ocular tissues and ocular fluids by the various methods of administration.

2. The toxic effects of the substances on the ocular tissues.

3. The effectiveness of each agent, variously administered, against experimental ocular infection.

4. Actual clinical results.

PENICILLIN

Most of the recent studies have dealt with penicillin. The penetration values with the several means of administration have been reviewed by Rycroft,[1] Sorsby,[2] Brown,[3] and others and may be summarized as follows:

1. Drops and ointments are useless for intraocular penetration of penicillin if the cornea is normal,[4, 5] but allow penetration through an inflamed cornea.[6]

2. The local methods that ensure penetration in the presence of a normal cornea are:

(1) Corneal bath.[5, 10]
(2) Cotton packs.[7]
(3) Iontophoresis.[4, 7, 8, 9]
(4) Subconjunctival injection.[1, 5]
(5) Direct anterior chamber injection.[11, 12, 13]
(6) Direct intravitreal injection.[14, 15, 16, 17]

3. Systemic administration does not produce inhibitory concentrations in the aqueous or vitreous humor except by massive doses and local administration attains much higher levels.

It may be definitely stated from the data acquired to date that local therapy with penicillin has proven superior to systemic therapy for the majority of ocular infections due to penicillin sensitive organisms.

There are many different methods of applying penicillin locally. Penicillin solution containing one hundred to 2500 units per cubic centimeter of normal saline can be safely used for drop therapy. Penicillin ointments may be prepared by dissolving 1000 to 10,000 units in a few drops of sterile water and beating this up in 10 grams of the sterile ointment base. Suitable bases include lanolin-petrolatum, hydrosorb, lanette wax, vaseline, carbowax and aquaphor. It must be remembered that certain ointment bases may be irritating and may retard epithelial regeneration.[20, 21, 22, 23, 24] They vary in their ability to retard epithelialization. Lanolin petrolatum and hydrosorb have the least inhibiting effect.[25] For this reason preference should be given to solutions when dealing with corneal abrasions. However, ointment preparations maintain their potency longer than solutions. The latter usually become impotent after forty-eight hours at room temperature. Lamellae containing 250 units have been employed,[2] but produce an uncomfortable stinging sensation [3] when first placed into the conjunctival cul-de-sac. Lamellae retain their potency for months at room temperature.

Many forms of eye cups have been devised for applying corneal baths with penicillin.[26, 27, 29] It is possible to damage the epithelium of the cornea if the concentration of the solution used is too strong or application has been made for too long. It is safe to use a solution containing ten to twenty thousand units per cubic centimeter for one hour, one to three times daily.

Iontophoresis with 1000 to 5000 units per cubic centimeter of normal saline with two milliamperes of current through the cathode for three to five minutes may be applied safely [7] once daily.

* Read, by invitation, before the Eye, Ear, Nose and Throat Section, The Medical Society of New Jersey, Atlantic City, May 22, 1946.

Cotton packs using 1000 to 10,000 units per cubic centimeter of saline may be applied for one hour at eight hour intervals [7] without producing corneal damage. Occasionally the cotton may mechanically abrade the cornea if care is not exercised.

Subconjunctival injections of 250 to 1000 units in 0.25 cubic centimeters of saline may be injected [2] at twelve hour intervals without undue reaction.[3] Crystals of penicillin [27] have also been used for corneal ulcers,[28] but definitely retard epithelialization [25] of corneal wounds. The technics of corneal bath, crystal application, iontophoresis, cotton packs, and subconjunctival injections require previous instillations of some local anesthetic. If indicated, 250 units of penicillin [9] can be safely injected into the anterior chamber [11] in 0.25 cubic centimeters of saline.[13] Such injections are painful, and the patient must be well anesthetized. Likewise intravitreal injections of 1000 units of 0.25 cubic centimeters may be used. Care must be taken not to strike the posterior surface of the lens with the injecting needle. The eye should be well anesthetized. This may be a damaging procedure in itself and should, therefore, be reserved for probable overwhelming infections.

In the accompanying table are listed ocular infections and the method and dosage for administration of penicillin best suited for their therapy.

PENICILLIN ADMINISTRATION IN OCULAR INFECTIONS
(Penicillin sensitive Organisms)

Type of Infection	Method of Administration	Dosage	Frequency of Application
1. Marginal Blepharitis	Local—ointment	500-1000 units per gram of base	Removal of crusts then ointment application 3 times daily
	Local—solution	1000-2000 units per cc. of saline	Painted on lid margins 5 times daily
2. Acute mucopurulent conjunctivitis	Local—solution	1000-2500 units per cc. of saline	Four drops applied every hr. for first 12 hrs., then every second hr. Continue treatment for 48 hrs. after apparent clinical cure to prevent relapse
3. Acute keratoconjunctivitis	Local—solution	As number 2	As number 2
4. Dacryocystitis	Local—solution	As number 2	As number 2 plus injection into and irrigation of sac with solution
5. Superficial eye injuries, e. g., corneal abrasions, acid, alkali burns, etc.	Local—solution	1000-2500 units per cc. of saline	Every two hours until lesions quiet
6. Deep keratitis including interstitial of luetic origin	Local—solution	Subconj. injection—250-1000 units/0.25 cc.	Once or twice daily
		or	
		Corneal bath 10,000 units/cc.	Once to three times daily for one hour each
		or	
		Iontophoresis—5000 units/cc.	Once or twice daily, 3 milliamp. for 2-3 min.
		or	
		Cotton pack—10,000 units/cc.	Every 8 hrs. for 1 hr. each
		or	
		Anterior chamber injection 250 units/0.25 cc.	Once—may repeat once in 24 to 48 hrs.
		or	
		Crystals—pure	Rub into previously curetted ulcer alternate days
	Plus systemic (where generalized body infection as well as corneal)	25,000 units	Every 3 hrs. intramuscularly 10-14 days

Type of Infection	Method of Administration	Dosage	Frequency of Application
7. Uveitis	As No. 6 combination of local and systemic therapy		
8. Iridocyclitis	As No. 6 combination of local and systemic therapy		
9. Infections after intraocular surgery	As No. 6 combination of local and systemic therapy		
10. Choroiditis	Systemic as in No. 6		
11. Optic atrophy	Systemic as in No. 6		
12. Optic neuritis	Systemic as in No. 6		
13. Cavernous sinus thrombosis	Systemic as in No. 6	(Heparin can also be used in addition)	
14. Orbital cellulitis	Systemic as in No. 6		
15. Vitreous infections	Local	Direct injection 2000 units/.25 cc.	Once within first 12 hrs. of onset if possible

In all cases, watch for signs of local or systemic sensitivity to penicillin. Some cases of marginal blepharitis will not respond to penicillin solution, particularly those due to seborrheic dermatitis. The British ophthalmologists [2,3] recommend liquor tinctorum * for this.

Non-bacterial conjunctivitis [2] and keratoconjunctivitis such as post herpetic, superficial punctate, dendritic and herpetic do not respond to penicillin.[3]

As suggested in the table, the combination of local and systemic methods of administration allows an attack on the primary focus in the body in addition to effecting high local intraocular concentrations.

Penicillin has proved of little value in nonspecific choroiditis and uveitis.[30] Luetic optic neuritis appears to respond to systemic penicillin.[31] The effect on luetic optic atrophy is not clear. Too little time has elapsed for adequate evaluation of the cases treated. Steele's [31] observations would seem to indicate that early cases respond better than late ones. In luetic interstitial keratitis, it is not certain whether the cornea is invaded by the active spirochete or whether the cornea is responding allergically to a luetic focus elsewhere in the body.[32] If the cornea is really invaded, local therapy should prove superior to systemic administration.

* Liquor tinctorum is a mixture of equal parts 0.5 per cent brilliant green and 0.5 per cent gentian violet.

The schedule of dosage and frequency of application suggested in the table are tentative and should be altered as soon as accumulating data indicates.

STREPTOMYCIN

Studies with streptomycin indicate that it penetrates the ocular fluids and tissues in a manner similar to penicillin.[33] Experience with experimental and clinical ocular infections is still meager. Based on penetration studies, streptomycin can be used in the concentrations of 5000 to 10,000 units per cubic centimeter of normal saline for drop application. Iontophoresis can be accomplished with the same strength solutions, and corneal bath with solutions containing 50,000 units per cubic centimeter. Ointments containing 5000 units per gram of base should prove adequate and safe. Intramuscular injections for systemic administration should be approximately five to ten times the unit concentration suggested for penicillin. Streptomycin may prove helpful in ocular infections due to Friedlander's bacillus, bacillus tularensis, brucella organisms, typhoid, early tuberculosis, hemophilus, influenzae and other gram negative bacillary infections.[34] Definite dosage schedules will have to await more clinical experience as the drug becomes more available in the near future.

NEWER MYDRIATICS

Other drugs have also been introduced into opthalmology. Dibutoline sulfate [35] and dimethyl aminoethyl benzilate etochloride [36,37] are new compounds with mydriatic and cycloplegic properties. E_3 was developed in Britain during the war as an atropine substitute. However, it is not as rapid or prolonged as atropine in its action. E_3 in one per cent solution in distilled water is equivalent approximately to one per cent homatropine solution. It has its maximum mydriatic effect in one hour and this wears off in five to six hours. Dibutoline sulfate was developed by Swan and White in the United States and it also approximates homatropine in activity. Chief usefulness of both the agents appears to be their ability to dilate the pupils of atropine and homatropine sensitive eyes.

ANTI-LEWISITE

During the war, Stocken and Thompson, working in Peters Laboratory, devised a compound which overcame the toxic effects of lewisite. This compound was first called DTH, meaning di-thiopropanol. It was later renamed British anti-lewisite or BAL. It is applied in the form of drops or ointment in 5 per cent concentration to the eye a few minutes after exposure to a perforating dose of lewisite, and it then negates the lewisite action. BAL is useful in arsenical dermatitis, mercurial poisoning and possibly cadmium intoxication. For this reason BAL may prove useful in eyes damaged by toxic heavy metal compounds.

FLUOROPHOSPHATES

Many chemical warfare investigators [40] have studied the physiologic and pathologic effects of the fluorophosphates. Of these, the diisopropyl derivative (DFP) has received the most attention. It is a powerful inhibitor of cholinesterase, and is much more potent than eserine in this respect. In the eye, DFP produces prolonged and marked miosis, ciliary muscle spasm and false myopia; and it decreases intraocular tension. Because of the potentialities of this long acting, powerful miotic, studies of its ocular pharmacology and trial in glaucoma were undertaken. In normal eyes, one drop of 0.5 per cent DFP in peanut oil will produce miosis that persists for two or three weeks. In chronic simple glaucoma, previously controlled by pilocarpine or eserine, DFP also maintained the visual fields and intraocular tension. DFP 0.5 per cent requires fewer daily instillations than either 1 per cent pilocarpine or ¼ to ½ per cent eserine to maintain the intraocular pressure in these eyes. DFP has lowered intraocular tension in some cases in which other drugs have failed. It overcomes the effects of atropine. Because of its potency, it has several undesirable and untoward ocular effects: visual blurring, brow pain, eye ache, spasm of accommodation and pericorneal injection. Further clinical work is required before its exact place in the antiglaucomatous armamentarium is decided.

SUMMARY

Local application of penicillin is better than systemic administration for controlling most ocular infestions due to penicillin sensitive organisms. A dosage schedule for ocular infections with penicillin and streptomycin was suggested.

Other new chemical compounds which may prove useful in ophthalmology are the cycloplegics, dibutoline sulfate and E_3; BAL, the British anti-lewisite compound, and DFP, a powerful anticholinesterase agent.

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INSTRUCTIONS FOR HOSPITALIZATION OF ELIGIBLE VETERANS

Prepared by Regional Office, Veterans Administration, Newark 2, N. J.

In applying for hospitalization the veteran is required to submit a completed VA Form P-10 "Application for Hospitalization or Domiciliary Care" to the Veterans Administration, Regional Office, 20 Washington Place, Newark. New Jersey.

The physician must completely fill out the medical certificate on the Form P-10. Under Section (4) of the medical certificate it is necessary to give the diagnosis and a statement as to whether the condition is or is not emergent. Section (5) should be completed in all cases. The physician's name and address should be legible. Incomplete medical certificates cause great delay in the hospitalization of veterans.

1. Emergency Conditions — For emergency conditions the physician should call the Regional Office at Newark, N. J., by *telephone* (Market 2-1470, Ext. 432, or 433), if possible before admission. If that is not possible, telephone contact should be made *not later than 72 hours after admission* so that proper authorization can be issued for hospitalization and treatment. The issuance of authorization is governed by the factors outlined under paragraph 3 below. In any event VA Form P-10 is required and should be mailed to the Veterans Administration, Newark 2, N. J. Existing regulations are specific governing the issuance of authorization within the period of 72 hours, and it is emphasized again that telephonic authority should be obtained within that time.

2. Non-emergency Conditions—It is necessary that completed Form P-10 be submitted to the Veterans Administration, at Newark, New Jersey. If it is proposed that the examining physician attend the veteran at a private hospital this information should be contained in a cover letter attached to the form. The issuance of authorization is again governed by the factors outlined under number 3.

3. *The issuance of authorization by the Veterans Administration* for treatment of veterans in *other* than VA or Federal Hospitals, i. e., in private hospitals by private physicians, is governed by the following combination of factors.

(a) *Eligibility* — Service-connection established previously by the VA; pending claim for the condition; trainee status under Public Law 16; emergency conditions in female veterans.

(b) *Nature of the Condition*—Emergency, inability to travel to nearest VA Hospital, etc.

(c) *Availabiilty* of appropriate bed in a VA Hospital within a suitable distance, taking into consideration the particular condition for which hospitalization is being sought.

4. Submission of Bills — The conditions outlined in paragraphs 3a, 3b, 3c, of "Instructions for Rendering Out-Patient Treatment" apply. Copies of this instruction sheet are available on request.

5. Forms—Copies of VA Form P-10 "Application for Hospitalization and Domiciliary Care" may be obtained on request.

TRIBUTE TO DR. COIT *

Paul Hosp, M.D., Newark, N. J.
Secretary, Staff of The Babies Hospital

Dr. Coit was born in Peapack, N. J., on March 16, 1854. He was the son of the Reverend John S. Coit, a Methodist minister. Dr. Coit lost his father at the early age of twelve. To support his mother and himself he obtained a position in a drug store. He worked hard and late, and many a night he would sleep under the counter in the store. A few years later he went to work in a pharmacy in New York City. He lived here with his grandfather. He was ambitious and thrifty and saved enough money to enter the College of Pharmacy of New York. He was graduated from this institution with honors. Later he served as a chemist and as an instructor in the College of Pharmacy. He then worked his way through the College of Physicians and Surgeons of N. Y., being graduated from this medical school in 1883. He served his internship in Newark, and then began general practice. This, however, did not continue long—his love and interest lay with children, and he soon gave all his time to the practice of pediatrics.

From the onset he became a champion of preventive medicine. He noted that the milk used in the home for children was far from good. Many diseases could be traced to impure milk.

We of the older group remember how these milk-borne diseases would leap at us each year. Each summer would bring what in those days was called summer diarrhea or complaint. Even in cool weather there would be outbreaks of gastrointestinal infections among children who were not breast fed. These were nearly always traced to the milk supply. Bovine tuberculosis was common.

MILK HYGIENE IN 1880

Do you know how milk was delivered to the consumer in those days? The containers were usually forty-quart cans. These cans were washed in the back yard, scrubbed with brush and soap, then put under the pump, rinsed until thought they were clean, then turned upside down to drain. The milk was procured across the road, direct from the cows. It was rich milk: it did have lots of cream in it and I am sure that it was also rich in bacteria. The milk from the pails was poured into the large cans and then cooled. Early in the morning, while still dark, these large cans were loaded into the wagon and the trip to the city begun. Milk was dipped out with a laddle and transferred to smaller delivery cans and from these it was poured into a receptacle which the housewife had sitting in the hallway. The driver would handle the horse reins—at the stop he would pull off the lid of the can, then dip out the milk. What a routine! Today we shudder at this procedure. Dr. Coit shuddered at it then. These unsanitary conditions, which he knew could be eliminated, urged him on in his life's work. It gave him the name of *Disciple of Pure and Wholesome Milk for Babies and Children.*

CERTIFIED MILK

With untiring effort he devoted years to the study of milk production, farms, barns, the milking of cows and the handling of the milk. He finally wrote a treatise and in 1889 he asked the Medical Society to investigate the problem. After two years, a committee of 42 physicians concluded "that this was of sufficient importance to engage the influence and coöperation of the entire Medical Profession." Nothing happened. Again in 1892 the plan was presented to the Practitioners Club of Newark (the strongest medical organization of the time in the state) and it met with its approval and endorsement. The project was without precedent and provided for a Commission of medical men, which by voluntary supervision and control of methods, made expert inspections of dairies and certified the product.

This original Commission was appointed by

* Read at the 50th Anniversary Meeting of the founding of the Babies Hospital, Newark, N. J., Jan. 30, 1946.

the Practitioners Club and is now known as the Essex County Milk Commission. In 1896, New York City copied the New Jersey plan and named a Milk Commission. There are now over 80 such Commissions in the United States, federated into a National Association. The product they certify is known as Certified Milk, a name coined by Dr. Coit.

I can not pass this point without saying it was difficult to find some producer who would go all the way to conform with the requirements set forth in this all-important set of rules regulating the production of Certified Milk. There was one man, a Mr. Stephen Francisco, who operated the Fairfield Dairies. He went all the way to conform to the satisfaction of the Commission. He was a co-worker of the physician. He deserves the associate credit of Certified Milk. His dairies were the model of cleanliness and perfection. Medical men and dairymen from all over the world visited his plants, and marvelled.

STATE PEDIATRIC SOCIETY

Dr. Coit was the first president of the State Pediatric Society. He was a dynamic figure. He made success of whatever he undertook. In Volume One of the Transactions in 1910 he spoke of *Factors in the Conservation of Child Life*. I have taken a few excerpts from that essay.

> The N. J. State Pediatric Society has imposed upon itself a great duty, and while it is incumbent upon me, as its first president, to be your leader, yet as individual members our duty is one and our opportunity is signally great for the fulfillment of the objects set forth in the constitution of our society, namely:
>
> First—To unite the physicians of the State who are engaged in the scientific study of the diseases of infancy and childhood.
>
> Second—To promote, by its concerted efforts, scientific medical research in the department of Pediatrics.
>
> Third—To foster a greater interest in pediatrics by the profession at large and to spread a knowledge of pediatrics among general practitioners.
>
> Fourth—To study the problems of infant mortality and to popularize a knowledge of infant hygiene and of the means for the protection of child life.
>
> The gift of children is the most precious gift of God to mankind. It is the natural right, of every child born into the world, to remain and grow to years of efficiency.
>
> Nearly one-quarter of the infants born in the centers of population perish during their first year. Almost one-third million of young children died in our own country last year.
>
> Conservation of child life is a question of vastly more importance to the American people and vital to the integrity of the nation than the conservation of minerals, rivers or forest preserves.

His whole life was devoted to trying to make this a better world, a better place for babies and children to live in.

THE BABIES HOSPITAL

Another great achievement of Dr. Coit's was the founding of the Babies Hospital. He felt that the general hospital of the day was not properly equipped to take care of children and infants. With his happy way of inspiring people, he presented the project to some of the most altruistic citizens of his community, and in a short time the Babies Hospital was a reality. It was not the modern building of our present hospital. Two adjoining brick buildings on the corner of High and Bank Streets comprised the original structures. They were old buildings, but staunch; their interior was brightened by painting everything with white enamel. Many a mother and father remembers the good work done within its walls. We have fond memories of this old Babies Hospital.

I must mention a few lines on Dr. Coit's foresight in infantile paralysis. At the time of the epidemic in 1916, he realized that there would be need for facilities for poliomyelitis victims. He therefore collected sums of money and one of his first acts was to acquire the services of a demonstrator from Boston who gave the nurses special instruction in massage and muscle training.

He was always doing something. When not attending meetings he would be writing papers. This valuable and active life suddenly terminated on March 12, 1917. He had been stricken with pneumonia, and his death was a shock to all who knew him. I have read the newspaper items written at the time of his death—they all praise him for his unselfish devotion to children; they tell over and over again how he procured pure milk for infants. They wrote of the wonderful work that Dr. Coit had per-

formed in reducing infant mortality, work that attracted the attention of the medical profession and laymen throughout the world. He had under his care infants from all corners of the globe. His name will be linked with that of men like Metchikoff and Pasteur. It will live forever in medical history. His loss to this country was a sad blow to the mothers he had comforted and to the others who knew him and appreciated his philanthropic work and admired his Christian life and humanitarian ideals.

But he left us with a heritage which we can be proud of; especially those of us who are a part of this hospital named in his honor. It is ours—it is yours to use it for the care and treatment of children.

Let me repeat here the tribute given at the Practitioners Club meeting in 1917, following the death of Dr. Coit. They stood in silence while Dr. Elmer G. Wherry spoke:

"It is impossible to tell in a few words, or in many words, my appreciation of Dr. Coit. It cannot be expressed by saying that he was a good man, nor by saying he was a great man. He was both good and great. He was gentle, kind and strong. He was indomitable and exacting, yet patient and considerate. He had great will power, steadfastness of purpose and perseverance. Though he took pride in his ancestry, his family and in his accomplishments, he was yet humble and modest; though an aristocrat, he was democratic in his feelings and associations. He was both a visionary and a doer of deeds. He saw visions and dreamed dreams, and after long years of persistent and patient effort his visions are realities, his dreams have come true. He worked alone to accomplish his great tasks. He had a large brain and a big heart.

"His memory is an inspiration. His good deeds are an example. His humanitarian and altruistic spirit still lives. His influence is immortal. He has left us a perpetual heritage."

842 South 12th Street, Newark

MAYBE WE'RE OVERSELLING MEDICINE. Pouring into the public press miracle stories about the marvels of modern medicine may be momentarily gratifying for the M.D. But it boomerangs in the long run. In spite of the breath-taking progress of our science, we still can't do much for many of our patients; those with cancer or multiple sclerosis or even arthritis, for instance. And when the patient finds that his doctor can't pull rabbits out of the hat with the magic wand which modern medicine men are supposed to manipulate, he thinks that his family M.D. is an old-timer and he looks for a stream-lined, glitteringly equipped "modern" clinic. It might be an act of self-preservation for medical organizations to push down the soft pedal when publicizing new medical discoveries.

Nor is this the only way in which a little public knowledge turns out to be a dangerous thing. Hearing of all sorts of trick x-ray techniques, newfangled special tests and recently trumpeted diagnostic gadgets, Mr. Regular Patient drifts in demanding these new notions on Medicine's counter. Of course, had he needed them, his doctor would have thought of it long ago. But having heard of the "latest thing in tests" he insists on it. Then, whining at the expense, he joins in a chorus of "Aye" to the verse "Doctors charge too much".

Patients were probably better off in this sense back in the days when the doctor's methods were distant and mysterious. Or is this just a quaint nostalgia not even worth thinking about in these super-civilized days?

ICE-BREAKERS IN THE FORM OF BANTER, facetiousness and conversation concerning the current World Series or latest murder case, are needless and out of order. There is never cause for the physician to indugle in incessant small talk. Perhaps it is a throw-back to the days of the barber surgeon. On the other hand, it is equally wrong for the physician to enter the sick room in long-faced, black-gloved gloom; the patient is already seized by numerous fears, and it is the duty of the physician to dispel these as smoothly as possible. The patient should be made to feel that the doctor has come to help him, not embalm him. Patients keenly resent having their opinions abruptly contradicted. Just as tactless is the physician whose opening remark is, "Well, what is the matter with you this time?" or "What! are you sick again?"

♠ ♠ ♠

The term "bedside manner" has come to lose its original meaning, and to connote instead an almost maudlin sentimentality.

♠ ♠ ♠

An occasional chance to look up from the bed instead of down upon it can, if he will let it, make him a much more human and considerate physician than he might otherwise be.—"Disease and the Man"—Lapham.

THE NEW PHARMACOPOEIA

The Committee of Revision, U. S. Pharmacopoeial Convention

The thirteenth pharmacopoeia will appear this November and become official in April, 1947. A striking feature of the current revision period has been a trend towards medicines having specific physiologic actions. On that basis such cardioactive drugs as *digitoxin, digoxin* and *lanatoside* have been included. Physicians will be glad to know that by limiting ergot to the alkaloids *ergotamine* and *ergonovine* (and their preparations), prompt and definite results can be depended on. The important representatives of the sulfa groups are, of course, included in U. S. P. XIII. The oral and injectable forms of *sulfamerazine* have been recognized. Both *penicillin sodium* and *penicillin calcium* have received pharmacopoeial listing. An effective vehicle for ointments in conditions in which fatty unguents are contraindicated, is recognized in the newly accepted washable ointment base, *hydrophilic ointment.* Another new ointment vehicle, designated *hydrophilic petrolatum,* is available for incorporation in aqueous solutions.

ENGLISH TITLES

When the physician or pharmacist picks up the new official book, he will observe a change in the order of the texts, for the drugs now follow each other in alphabetic order by English titles. Thus, *digitalis* is followed by all of its preparations and also by *digitoxin* and *digoxin* and their preparations; *belladonna leaf* is followed by the extract, fluidextract and tincture, etc. The Latin titles are retained in subordinate headings but they do not determine the alphabetic position of the monographs. The alphabetic order is determined (for the first time) by the English form of each name.

REFERENCE STANDARDS

More and more U. S. P. assays and tests, both chemical and biologic, are requiring reference standards. This has become an important and increasingly responsible pharmacopoeial service. These products are used by manufacturers as a standard against which to check their production line and also by enforcement officials in determining the identity, purity and strength of commercial products. In the new melting point reference standards, the USP has established an unusual use for standards as they are employed to determine the degree of accuracy of the various types of melting point apparatus allowed. USP reference standards also provide a basis for research into new products. The standards for unofficial substances have been limited up to this time to *trypsin, calcium pantothenate* and *pyridoxine hydrochloride,* but authority has just been given for the preparation and distribution of reference standards for the amino acids which have been proved essential to health.

Wherever available, the international biologicals are used as a basis for comparison and so far as possible, the USP and the international standards are maintained on a parity.

The USP reference standards now available are:

Vitamin A
Vitamin D
Vitamin D for poultry food
Ascorbic acid
Calcium pantothenate
Cholic acid
Diethylstilbestrol
Digitalis
Epinephrine
Ergotoxine ethanesulfonate
Estrone
Melting points
Nicotinic acid
Potato starch
Ouabain
Posterior pituitary
Pyridoxine hydrochloride
Riboflavin
Sulfanilamide
Thiamine hydrochloride
Trypsin

Standards are now being prepared for choline, digitoxin, estradiol, heparin, lanatoside, testosterone, nicotinamide and progesterone.

SPANISH EDITION

USP XII has been translated into Spanish and made the official pharmacopoeia in Costa

Rica, Cuba, Nicaragua, Panama, the Philippines, Puerto Rico, Uruguay and in the Dominican Republic. It is expected that USP XIII will be at least as widely distributed.

PHARMACOPOEIAL POLICIES

The future of the Pharmacopoeia depends on maintenance of its present program, i. e. restriction of its scope to approved medicines with preparations of these for their most efficient administration, the selection being made with exacting, scientific care and without commercial influence or bias. Then the standardization of these with the aid and approval of the most able authorities in the country, the program including the collaboration of the enforcement officials at Washington, the research and teaching groups in the universities and colleges, and the scientific staffs of industry. Discussions and proposals should always be in the open but the Committee of Revision must retain the final decisions and these decisions will be judicial in character. Recent experiences indicate an increasing desire to participate in such a program, with the Pharmacopoeia accepted as a desirable and logical leader.

ADDITIONS TO U. S. P. XIII

The following new items have been given recognition in USP XIII:

Aluminum phosphat gel
Aminopyrine tablets
Anhydrohydroxyprogesterone tablets
Anticoagulant acid citrate dextrose solution
Antimony sodium thioglycollate
Antimony sodium thioglycollate injection
Apomorphine hydrochloride
Bentonite magma
Benzyl benzoate
Benzyl benzoate lotion
Benzyl benzoate, saponated
Benzalkonium chloride (sold under the trade-marked name "Zephiran chloride")
Calamine
Calamine lotion
Carbachol (sold under the trade-marked name "Doryl")
Carbachol injection
Cholera vaccine
Cholesterol
Corn oil
Cupric citrate
Cupric citrate ointment
Desoxycorticosterone acetate
Digitoxin
Digitoxin injection
Digitoxin tablets
Digoxin
Digoxin injection
Digoxin tablets
Diphtheria and tetanus toxoids
Diphtheria and tetanus toxoids, alum precipitated
Diphtheria toxoid, alum precipitated
Ethylenediamine solution
Gas gangrene antitoxin
Helium
Hexlyresorcinol pills
Hydrophilic petrolatum and hydrophylic ointment
Iodopyrin (trademarked "diodrast")
Lanatoside C
Liver with stomach (trademarked "lextron")
Methacholine chloride (trademarked "mecholyl chloride")
Methylben
Methyl testosterone
Morphine injection
Nicotinamide injection
Papaverine hydrochloride and injection
Peanut oil
Penicillin calcium
Penicillin sodium
Penicillin dental cone
Penicillin injection in oil and wax
Penicillin ointment, troches and tablets
Plague vaccine
Progesterone
Protamine zinc insulin injection
Propylben
Riboflavin injection
Ringer's solution, lactated
Sesame oil
Sodium ascorbate injection
Sodium lactate injection
Sodium laurylsulfate
Sodium morrhuate injection
Stearyl alcohol
Sulfamerazine
Sulfamerazine tablets
Sulfamerazine sodium
Suramin sodium
Surgical sutures
Coal tar
Coal tar ointment
Testosterone propionate
Testosterone propionate injection
Tetanus toxoid, alum precipitated
Thiamine hydrochloride injection
Thiopental sodium (sold under the trade-marked name "Pentothal sodium")
Triethanolamine
Tuberculin, purified protein derivative
Typhus vaccine, epidemic
Vinyl ether
Yellow fever vaccine

THE PHYSICIAN AND SOCIAL SECURITY

By PETER KASIUS, Regional Director, Social Security Board

What does social security mean to doctors, dentists and nurses who are not presently included under the provisions of the insurance programs of the Social Security Act?

The phrase "social security" has come to have such an inclusive meaning that the term has lost its usefulness to describe any one specific program under the Social Security Act In its inclusive meaning, social security means, above all, full employment and full production. It must also include decent housing, education and health, and the elimination of the hazards caused by death and unemployment.

Excluding the larger sense of the term "social security," doctors and nurses have an important role in the two insurance programs under the Social Security Act. They are: (1) Unemployment Insurance, and (2) Old-Age and Survivors Insurance. True, they have a very limited part in their participation in the old-age and survivors insurance program. They have certain rights and duties under the provisions of this program, depending on their employment.

Nurses who are employed in doctor's offices or private hospitals fall within the scope of the present old-age and survivors insurance program and doctors, as employers, have the obligation of reporting their wages to the Government.

THE DOCTOR'S RESPONSIBILITY

But beyond this employers' obligation, doctors have a social duty which they can perform. Doctors and nurses who come into intimate touch with families can fill a necessary social link by spreading information to men and women who frequently do not know that they have monthly old-age and survivors insurance coming to them. Although the Social Security Board has endeavored to acquaint workers and their families with their rights under the insurance program, many workers who have already earned credits counting towards benefits still have meagre knowledge of the protection which this insurance provides for them in their old age and for their families in the event of the breadwinner's death.

Because many workers think that retirement benefits will come to them automatically when they stop work, some do not file their claims immediately on retiring. Because many workers still think of social security as an "old-folks' program"—they fail to inform their families about their rights under the law. Time after time widows, dazed and at a loss where to turn, come to the local offices of the Social Security Board as a last resort. Sometimes they are sent in by a funeral director, a minister, a social worker, or by the doctor who attended the deceased. Sometimes they come in because a neighbor heard about social security on the radio and gave them hope. Frequently they expect at most a lump-sum benefit. Their husbands paid social security taxes for years, they say. Can't they get back his contributions?

A doctor or a nurse could be of material help in getting information about social security benefits to their patients and to the families with whom they come in contact. Families in which the breadwinner dies especially need to know their rights. The need for this information is great among those who have reached the age when they can no longer work in a factory, office or at other industrial jobs. Wouldn't the doctor's opportunities be many, since he is among the first to whom families turn when bereavement comes? He should have the following basic information about a program which spells insurance to family groups when a worker dies or when a worker reaches the age of 65 and the doctor has cautioned him about working.

OLD-AGE AND SURVIVORS INSURANCE

Old-age and survivors insurance operates at present only for those employed in private industry or business—in factories, mills, mines, stores, offices, banks, hotels, restaurants, gas stations, and similar places. The system provides an income for the worker when he is

old and retires and for his family when he dies.

To qualify for retirement benefits a worker must be "fully" insured. Roughly speaking, to become fully insured, a wage earner must have worked in a covered job at least half the time between the beginning of the program on January 1, 1937 (or between the time he was 21 if that occurred at a later date) and the date on which he reaches 65 or dies. Retirement benefits are paid to:

1. The wage earner when he is 65 or older and stops work.
2. His wife when she is 65.
3. His children under 18.

These benefits are payable to the worker and his wife until death; to the children until age 18.

Any of the monthly benefits provided under the law are available to the survivors of workers who die "fully" insured. Monthly benefits are provided for the worker's family during the children's growing years, however, even when the wage earner dies having acquired only "currently" insured status. To become "currently" insured less work, generally speaking, is required; a worker must have been employed in covered work for only half of the last three years of his life.

Monthly benefits are payable to the following survivors of "fully" insured workers:

1. Children. These receive monthly payments until they are 16 (or 18 if still in school).
2. Widow with children in her care, regardless of her age. Until her youngest child is 18, the widow receives monthly payments provided she does not remarry. The payments stop when the youngest child is 18, but begin again when the widow is 65 and continue until death, unless she remarries.
3. Widow at age 65. She receives monthly payments, regardless of whether she has children, provided she has not remarried.
4. Dependent parents. If the deceased worker left neither widow nor child under 18, dependent parents receive monthly payments when they reach the age of 65.

Monthly benefits are payable to the following survivors of "currently" insured workers.

1. Children. These receive monthly payments until they are 16 (or 18 if still in school).
2. Widow with children in her care regardless of her age. Until her youngest child is 18, she receives monthly payments provided she does not remarry.

Widows with children may work in covered employment without affecting the benefit payments to their children. For each month in which the widow earns as much as $15 in covered employment, however, her benefit payment is suspended. Many widows exercise this option, since their earnings usually exceed the benefit which they alone receive. It is possible for a widow, or any other beneficiary whose benefits are suspended because of work in covered employment, to go on and off the benefit rolls as her employment ceases and begins again. Thus, some widows who could not obtain or engage in steady employment may supplement their incomes with seasonal jobs, without impairing their future benefit rights.

LUMP SUM PAYMENTS

Lump-sum death benefits are payable in the case of either "fully" or "currently" insured workers, to a near relative or person who paid the funeral expenses. If the deceased worker leaves no one immediately entitled to monthly benefit payments, then a lump-sum death payment is made to the widow, child, grandchild, or parents. If none of these relatives is living, a lump-sum payment may be made to the relative or other person who paid the funeral expenses.

FILING OF CLAIMS

In order that no payments may be lost, claims for benefits should be filed immediatley after the insured worker's death. Monthly payments to survivors are retroactive, but for not more than three months prior to the month in which a claim is filed. Thus if a claim is not filed until the fourth month after the month of the insured worker's death, one month's payment is lost. Claim for the lump-sum death benefit must be made within two years after the death of the insured person.

The Social Security Board is especially eager that doctors stress the following:

1. Every worker in covered employment should visit or write the nearest field office when he is 65, whether or not he intends to continue working.
2. The immediate family or near relative of

every worker who has ever been employed in a covered job should, upon his death, visit or write the nearest field office without delay, whether or not they know the worker was insured and that benefits may be due them.

LOOKING AHEAD

Old-age insurance will provide a minimum income for hundreds or thousands of old people when the wage earner must or wishes to stop work. This income is theirs as a right based on their contributions and earnings under the insurance system. *Survivors' insurance,* based on similar rights, will enable many widows to devote their energies to the care of their children and their homes, and will enable children to continue schooling, rather than to keep or seek paid work. Survivor benefits also will provide monthly income for aged widows of insured workers and, in certain circumstances, aged parents who have been dependent on the wage earner.

But should this insurance protection be given only to workers who have been employed in "covered" jobs—such as work in a factory, mill, mine, shop, store, office or other place of business or industry? The Social Security Board believes that it should *not* be so restricted. It has found during the past few years that extension of coverage to include twenty to twenty-five million additional employees and self-employed persons is the most urgent single need in the old-age and survivors insurance program.

Many people who depend on earnings throughout their lives have no opportunity to earn credits toward retirement or protection of their survivors under this or any other public system. This lack is especially great among agricultural workers, domestic workers in private homes, and self-employed persons.* Together, these groups comprised some fourteen million persons (1940 census). Public employees and employees of nonprofit organizations—hospitals, colleges, churches, private social agencies, and the like—characteristically lack survivor protection, and often lack provision for retirement, under any organized plan. On the basis of the 1940 census it is estimated that, under peacetime conditions, public agencies and nonprofit organizations and institutions employ about five million persons.

While limitation of coverage is the most serious shortcoming of this program, the Board has made other recommendations to improve the old-age and survivors insurance program. Among these are:

1. Protect the insurance rights of members of the military services.
2. Revise the benefit formula to assure higher benefits for low-paid workers.
3. Raise benefits generally by revising the formula for computing the average monthly wage, on which benefit amounts largely depend. This revision would exclude periods in which the worker had little or no employment, which now operate to reduce benefit amounts.
4. Provide a more liberal "work clause" than the present one, which provides for suspension of benefits for any month in which the beneficiary earns as much as $15.
5. Reduce the eligibility age for women from 65 to 60. This would not change the present plan which provides benefits for widows, regardless of their age, while they have dependent children in their care.
6. Provide for annual recomputation of retirement benefits where this would be advantageous to the worker and his family.
7. Remove the school attendance requirement for eligibility for children aged 16 or 17 years, experience having shown that virtually all children of those ages attend school when feasible.

The Board has made other recommendations to improve the social security program in connection with unemployment, public assistance and health insurance, all this in their desire to make the social security program an even stronger bulwark of social stability, economic progress and full enterprise.

Note: For further information on this subject, write to Manager, Social Security Board Field Office, 45 Branford Place, Newark 2, N. J., or 402 East State Street, Trenton 9, N. J. Field offices of the Board are also located in Atlantic City, Bridgeton, Camden, Elizabeth, Jersey City, Passaic, Paterson and Perth Amboy. For local address, call the post office.

* Most physicians are in this "excluded" category.—H. D.

STATE ACTIVITIES

VETERANS' CARE PLAN

The plan provided for under the new contract between Medical Service Administration of New Jersey and Veterans Administration, dated June 18, 1946, is now in operation. It supersedes the plan under the February contract.

The new contract provides that Medical Service Administration "will engage one or more competent medical representatives to be stationed at and operate from the Veterans Administration Regional Office".

The functions of this medical representative (or representatives) in brief will be: (1) To certify a list of competent physicians throughout the state to render examinations and treatments to veterans. (2) To review the work of these physicians to the end that examinations and treatments are adequate, satisfactory and in accordance with established standards. (3) To make such investigations as Veterans Administration may request concerning complaints, deficiencies or inadequacies of reports made by examiners and to submit reports and recommendations thereon to Veterans Administration and Medical Service Administration. (4) To serve as liaison officer between Veterans Administration and Medical Service Administration but not as a supervisor of Veterans Administration activities or employees.

Veterans Administration will provide office space, equipment, clerical assistance and telephone service.

Veterans Administration will pay Medical Service Administration $10,000 a year, payable quarterly in arrears, but the amounts so paid will not exceed the amounts expended or incurred by Medical Service Administration.

Under the new plan authorizations for examinations and treatments will be issued directly from the Regional Office of Veterans Administration to the physician. The list of over 3,000 participating physicians, in accordance with their type of practice, maintained under the previous plan, will be continued. The fees paid physicians will remain the same as under the old plan.

The new plan will prove much more satisfactory than our first project. It should expedite the medical care of the veteran and protect the interest of the private practitioner of medicine.

It must, however, be remembered that the administration of medical care for service-connected disabilities among the 600,000 veterans of New Jersey by private physicians, is a formidable problem. It is a new task for both the profession and Veterans Administration, and difficult administrative problems will arise and must continue to arise until a satisfactory solution for the entire program is evolved. It is the sincere hope of Medical Service Administration that the problem will be satisfactorily met by the voluntary cooperation of the profession.

PAYMENT FOR SERVICES PREVIOUSLY RENDERED

Vouchers covering services rendered under the old plan and reported up to July first have been submitted to the V. A. A voucher covering later cases will be submitted on August 1st. We hope to close out our indebtedness under the old plan by September, but whether we can depends upon the promptness with which physicians return their reports to Medical Service Administration and the promptness with which Veterans Administration pays Medical Service Administration in accordance with submitted vouchers.

One voucher has been paid. The services listed on this voucher were those reported to Medical Service Administration before March 30. Checks for these services have been mailed to the physicians rendering the authorized services. Checks for services listed on later vouchers will be mailed promptly as voucher payments are received from Veterans Administration. Many physicians billed Medical Service Administration for services in excess of the authorization. Such unauthorized services are not payable by Veterans Administration.

Norman M. Scott, M.D.

THE PRACTITIONER AND DRUG RESEARCH

The American Medical Association now has a "Therapeutic Trials Committee" to organize clinical studies of drugs which have been offered for treatment. This committee will seek for a sponsor for any approved clinical research project. The practitioner has a two-fold relationship to this new agency. First, he may suggest that the committee sponsor a research project because of some experience he has had with a certain drug which he cannot confirm due to the limitations of his practice. Second, he may ask the committee to sponsor a clinical

research project of his own if he feels he has sufficient case material to give a proposed drug a fair trial. Forms for the purpose of submitting requests for sponsorship of such clinical research projects are available on application to the Therapeutic Trials Committee, American Medical Association, 535 N. Dearborn St., Chicago 10.

ASSOCIATES AVAILABLE

The following New Jersey physicians are available for association as indicated. If interested in establishing contact with any of these doctors, write to The Medical Society at 315 West State Street, Trenton 8, New Jersey. Indicate whether you are referring to notice 5, notice 6, notice 7, etc.

5. GENERAL PRACTITIONER or INDUSTRIAL SURGEON, age 39, interested in part-time position as office assistant to industrial surgeon or general practitioner in Newark area.

6. OBSTETRICIAN or GENERAL PRACTITIONER, age 42, desires placement as office associate to obstetrician or general practitioner in Newark area.

7. GENERAL PRACTITIONER, veteran, age 48, licensed in N. Y. and N. J., desires placement as office assistant or associate with physician in any specialty. Paterson, Hawthorne, Clifton area preferred.

8. GENERAL PRACTITIONER, veteran, age 34, who has had residency in neuropsychiatry, licensed in both N. Y. and N. J., interested in becoming associated with a group as general practitioner or as neuropsychiatrist preferably in northern New Jersey.

9. INTERNIST, veteran, age 39, army classification as gastro-enterologist and internist, desires to locate in Paterson or northern New Jersey area, interested in association if practice can be limited to internal medicine.

10. GENERAL PRACTITIONER desires association in a medium sized community preferably near Paterson.

11. GENERAL PRACTITIONER, age 27, desires to associate himself with a general practitioner or internist anywhere in New Jersey.

12. SURGEON, veteran, age 31, army experience in orthopedics, battle casualty surgery, proctology and general surgery, interested in associating himself with surgeon or with general practitioner who does fair amount of surgery; especially interested in proctology and in general surgery. Prefers northern New Jersey.

13. ANESTHETIST and SURGEON, age 30, veteran, holds N. J. and Penna. licenses, desires assistantship in industrial surgery, anesthesia or general surgery. Prefers Camden County or Morris County area.

14. GENERAL PRACTITIONER desires association, preferably in an industrial area; age 28, former army battalion surgeon. Any opportunity and any part of New Jersey will be considered.

15. RADIOLOGIST, eligible for American Boards, fully trained in both diagnostic radiology and radiation therapy, desires association with certified radiologist in office or hospital, part time or full time, preferably in Northern New Jersey.

A physician licensed in N. J. interested in (a) finding an office associate or (b) securing placement as an office associate may send a brief notice to that effect, listing essential details, to Executive Offices, Medical Society of N. J., at 315 West State Street, Trenton 8, N. J. There will be no charge for publication, but these notices will not be used to advertise practices, offices or equipment for purchase or sale. This free service is available to individual physicians only and not to companies or business organizations. August 20 is deadline for September notices.

SUPPLEMENTARY LIST OF MEMBERS NO. 4

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

Cortese, Joseph T., 517 Roseville av., Newark (7)
Cupauioli, Richard A., 30 Lenox pl., Maplewood (7)
Finby, Nathaniel, 46 Main st., Netcong (14) (formerly Finklestein)
Harrington, Walter L., 104 S. Munn av.,E.Orange(7)
Inge, Theodore R., 336 Halsted st., East Orange (7)
Jordan, Alexander, 238 E. Main st., Manasquan (13)
Lamy, Anthony W., 560 Newark av., Elizabeth (20)
Lifland, Bernard D., 70 Shanley av., Newark (7)
Longley, Wm. H., Jr.,N.J.St.Hosp.,Greystone Pk.(14)
Miller, Eugene L., 136 Renner av., Newark (7)
Moir, John, 18 N. Main st., Cape May CourtHouse(5)
Morrison, Caldwell, 11 N. Ridgew'd rd., S. Orange(7)
Murphy, Albert T., 1108 Anna st., Elizabeth (20)
Oestreicher, Harry, Picatinny Arsenal, Dover (14)
Permison, Michael, 94 Lyons av., Newark (7)
Schwarz, Leopold J., 237 E. Pine av., Wildwood (5)
Strahan, Frank G., 473 Broadway, Long Branch(13)

ASSOCIATE MEMBER

Cassio, William L., 226 Norfolk st., Newark (7)

NUTRITION IN EVERYDAY PRACTICE

S. William Kalb, M.D., Newark, N. J.

Chairman Nutrition Committee

1. *Which are more nutritious — fresh, or canned fruits and vegetables?*

   They have about the same food value.

2. *I have used multiple vitamins containing vitamin C in ecchymosis without result. What can you suggest?*

   Supplement the patient's diet with foods high in vitamin C such as: citrus fruits, cantaloupe, cherries, strawberries, asparagus, beet greens, brussel sprouts, broccoli, cabbage, cauliflower, dandelion greens, kale, parsley, green peppers, spinach, tomato, turnip greens, watercress, and liver. In addition, prescribe the basic vitamin formula with 300 mg. of vitamin C per day.

3. *What is protein hydrolysate?*

   Amino acids are produced from proteins by boiling with strong acids or alkalies; or by heating in an autoclave at 150° C. for several hours, and by digestion with proteolytic enzymes. The product thus obtained is protein hydrolysate. (Hydrolysis is the digestion of proteins.) This mixture is rich in total amino acids.

4. *What is the value of amino acid therapy in ulcerative colitis?*

   In this disease, the loss of nitrogen may be as much as 9.3 grams a day. This loss can be minimized by the use of protein hydrolysate. Other conditions, such as kidney diseases, hyperthyroidism and severe burns; and indeed wherever there is nitrogen loss, will benefit by the use of this drug.

5. *I see many patients who have generalized or local edema with a secondary anemia but without cardiovascular renal disease. Are these nutritional edema?*

   Yes. Undoubtedly these patients have been on diets high in carbohydrates and low in protein and calories. Rapid relief will follow if they are placed on adequate diets which are high in proteins.

6. *What laxatives are the least irritating to the intestinal tract and at the same time do not disturb the nutritional factors in the digestion?*

   Bran; whole wheat cereals with molasses and fruit; phenolphthalein.

DEVASTATED MEDICAL LIBRARIES

Physicians, medical societies, and organized scientific groups able to send scientific books and periodicals to war-devastated libraries abroad, should send them prepaid to American Book Center, c/o the Library of Congress, Washington 25, D. C. More details as to what is needed and how to ship are obtainable from Kenneth R. Shaffer, Study-S-46, Deck A, Library of Congress, Washington 25, D. C. The following letter to The Medical Society of New Jersey is published for the information of all concerned.

During the war, the libraries of half the world were destroyed by the impact of battle and in the fires of hate and fanaticism. Where they were spared physical damage, they were impoverished by isolation. There is an urgent need for the printed materials which are basic to the reconstruction of devastated areas and which can help to remove the intellectual blackout of Europe and the Orient.

The need is so urgent, scientists working in Europe are so handicapped, that surely those of us working near well-equipped libraries will be willing to sacrafice the convenience of an "office copy" in order to provide *library* facilities for less fortunate colleagues. Please give this appeal your personal interest and attention.

There is need for a pooling of resources, for coordinated action so that the devastated libraries of the world may be re-stocked as far as possible. The American Book Center for War Devastated Libraries, Inc., has come into being to meet this need. It is a program that is born of the combined interests of library and educational organizations, of government agencies, and of many other official and non-official bodies in the United States.

The American Book Center is collecting and is shipping abroad scholarly books and periodicals which will be useful in research and necessary in the physical, economic, social and industrial rehabilitation and reconstruction of Europe and the Far East. The Center cannot purchase books and periodicals; it must depend upon gifts from individuals, institutions and organizations.

Medical and scientific books and periodicals constitute the most important type of material needed, and it is needed *now*. We feel sure that the members of your Association will want to help their suffering colleagues in war-torn Europe and Asia.

E. R. Cunningham, Chairman,
Division of Medical Literature Committee
on Books for Devastated Libraries.

COURSE IN NEUROPSYCHIATRY

An intensive course in neuropsychiatry, available without cost to veterans, and (on payment of tuition fee) to other physicians is announced by Rutgers University Extension Division in cooperation with the N. J. Neuropsychiatric Association. Classes will be held in Newark (beginning September 9 and terminating December 9) on Mondays, Wednesdays and Fridays from 7 to 9 p. m. Tuition fee is $100. Veterans who wish to take advantage of the "G. I. Bill of Rights" will write to Veterans Administration (20 Washington Place, Newark 2) and ask for VA form 1950. This form, together with a photostat of the discharge certificate, is then returned to the V. A. which issues a "certificate of eligibility" which, in turn, may be used in lieu of tuition fee when enrolling for the course. Details are obtainable from Dr. Henry A. Davidson, 533 Mt. Prospect Avenue, Newark 4, but checks should be made payable to *Rutgers University*. Monday evenings will be devoted to neuro-anatomy (September 9 to October 23) and to neuro-pathology (October 25 to December 9). Lectures and demonstrations in clinical neurology will be on Wednesdays at 7 p. m. The course in psychobiology runs from September 11 to October 23 on Wednesdays at 8 p. m. Fridays from 8 to 9 p. m. will be devoted to neuro-roentgenology (September 13 to October 23), neuro-physiology (October 25 to November 15), and electro-encephalography (November 22 to December 6). Lectures on psychiatry will be delivered Fridays at 7 p. m. Physicians may take part-courses at reduced fees Enrollment applications and full schedules may be obtained from Dr. Davidson at the address given above. The faculty will include instructors at Neurological Institute and Psychiatric Institute as well as experienced New Jersey practitioners.

OBITUARIES

DR. REEVE L. BALLINGER

Dr. Reeve L. Ballinger of Arlington died of a heart attack at his summer home in Oceanport on July 17. He had been a practitioner in West Hudson for 32 years.

Dr. Ballinger, who was 58, was born in Camden. He was graduated from Philadelphia College of Pharmacy in 1908 and received his medical degree from Jefferson Medical College in 1913. He started practice in Kearny and moved his office to his home in Arlington in 1919.

Dr. Ballinger was on the staff and a supporter of North Newark Hospital soon after it was founded in 1936 and continued as a member of the staff and executive board when it became American Legion Memorial Hospital in 1940. For 30 years he was in charge of West Hudson clinic of the Hudson County Tuberculosis Hospital in Kearny.

During his career he was associated with the medical staff of Jersey City Medical Center and St. Barnabas's Hospital, Newark. He was instructor of student nurses at St. Barnabas's from 1920 to 1933.

Dr. Ballinger was president of the Hudson County Medical Society in 1938-39. He served The Medical Society of New Jersey well and faithfully for many years, being active on its cancer control and welfare committees, and serving as chairman of the Subcommittee on Medical Practice, and of the Joint Committee of The Medical Society and the N. J. Pharmaceutical Association.

DR. EDWIN CRONK

Dr. Edwin I. Cronk, medical inspector of the public schools of New Brunswick and health officer of that city since 1911, died on July 20 at the age of 69. A leader in preventive medicine, especially among children, Dr. Cronk began his medical practice in New Brunswick upon graduation from the Hahnemann Medical College of Philadelphia in 1900. He served as city physician for a decade, and then assumed the office of Health Officer. He is credited with having initiated diphtheria immunization work in Middlesex County's school systems. Dr. Cronk established several child hygiene clinics in New Brunswick. Always an ardent football fan, he served as both trainer and physician to the football team of the New Brunswick High School.

DR. FLORENCE E. VOORHEES

One of the leaders among New Jersey women physicians, Dr. Florence E. Voorhees died on July 20 at her home in Newark. A native of Woodbridge, Dr. Voorhees attended Mt. Holyoke College and in 1898 matriculated at the Women's Homeopathic Medical College. In 1902 she was licensed to practice in New Jersey and moved to Spring Lake. There she engaged in general practice until 1910 and then went to central Europe for graduate study in obstetrics and gynecology. In 1911 she returned and opened her office in Newark. She was for many years associated with the medical staffs of the Presbyterian and St. Barnabas Hospitals in Newark and the General Hospital in East Orange.

THE BULLETIN BOARD

The American Congress of Physical Medicine meets September 4 to 7 at the Hotel Pennsylvania in New York City. In addition to the usual scientific program, a systematic three-day course in physical therapy will be given. Details are obtained from the Congress, 30 North Michigan Avenue, Chicago 2.

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Ophthalmologists are reminded of a three-day conference sponsored by the National Society for the Prevention of Blindness. The conference will be held at the Hotel Pennsylvania in New York City beginning November 25. For detailed program, write to the National Society at 1790 Broadway, New York City 19.

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An up-to-date revision of the helpful pamphlet *Questions and Answers on Vaccination* (prepared by the U. S. Public Health Service) is available on request to the Superintendent of Documents, Washington 25, D. C. Price is 10 cents a copy, with discount of 25 per cent on orders of a hundred or more copies.

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Phonograph recordings of plays designed to educate the public to a sound and sympathetic approach towards mental illness are now available through the National Mental Health Foundation, Box 7574, Philadelphia 1, Pa. Each represents a 15-minute dramatization and is ideal for presentations to lay groups.

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Gynecologists and obstetricians should write to Dr. Paul Titus, 1015 Highland Building, Pittsburgh 6, Pa., for recent changes in the rules of the American Board of Obstetrics and Gynecology. Next written examination of this Board is February 7, 1947.

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An advisory committee on amino acids has been set up by the U. S. Pharmacopoeia Revision Committee. It will cooperate with all individuals and groups interested in protein hydrolysates and amino acids. When standards are available, such products will find a place in the pharmacopoeia. Interested physicians should write to that committee, c/o Dr. E. F. Cook, 4738 Kingsessing Avenue, Philadelphia 43, Pa.

An orientation course in clinical allergy is announced for October 7 to 11 in Milwaukee. Inclusive fee is $40.00 and the faculty is selected by the American Academy of Allergy. For further details write to the Dean, Marquette University School of Medicine, Milwaukee 3, Wisconsin.

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The Mississippi Valley Medical Society will hold its annual post-graduate session September 25, 26 and 27 at St. Louis. There will be papers on every specialty of medicine and surgery. Total enrollment fee is $5.00. For details write to Dr. Harold Swanberg, Mississippi Valley Medical Society, W. C. U. Building, Quincy, Illinois.

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The American College of Physicians urges all doctors to reserve the week of April 28, 1947, for the annual session to be held in Chicago. For further details write to the College at 4200 Pine St., Philadelphia 4.

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New Jersey was honored last month by the election of Dr. Clarence R. O'Crowley of this state as president of the American Association of Genito-Urinary Surgeons.

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The National Arthritis Foundation announces the selection of Lionel Barrymore as Chairman of its Board of Sponsors. This Foundation is endorsed by high officials of the A. M. A. and is "devoted to the free care of arthritis victims". For further information about the work of the foundation, write to it at 11 West 42d Street, New York City 18.

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The Biologic Photographic Association invites all interested M.D.s to attend its meeting at the Hotel Bismarck in Chicago September 6, 7 and 8 this year. Endoscopic and photomicrographic technics will be reviewed and demonstrated.

COUNTY SOCIETY REPORTS

BERGEN COUNTY

H. E. Reinhold, M.D., Reporter

The annual field day and installation of officers of the *Bergen County Medical Society* was held at the Bergen Pines Hospital, Oradell, N. J., on the afternoon of June 19, 1946.

During the afternoon, several enjoyable hours were spent in the playing of softball, quoits, archery, etc.

The meeting for installation of officers was called to order by the president, DR. FREDERICK DILGER, at 5:15 p. m.

ELECTIONS TO MEMBERSHIP

To Regular: Dr. Robert J. Gross, Teaneck, N. J., by transfer from the Kings County Medical Society; Dr. Bernard Glick, Lyndhurst, by transfer from Brooklyn; Dr. John P. Reitnauer, Tenafly, by transfer from Hudson County.

To Associate: Dr. Stuart Alan Mason, Ridgewood, N. J.; Dr. Frank Drew, Jr., Leonia, N. J.; Dr. Thomas A. Garrett, Hackensack, N. J.; Dr. Eduard Dana, Hackensack, N. J.; Dr. Charles P. Campbell, Hackensack, N. J.; Dr. Stephen Bednarz, Wallington, N. J.

It was regularly moved and seconded that the secretary cast one ballot for the election of the above candidates. It was so done and the candidates were duly elected to membership.

President Dilger announced that he had the pleasure at this time of turning over the gavel to the newly elected president, DR. ALBERT W. CLOUD. Dr. Dilger said that he hoped that Dr. Cloud would have the cooperation that he had during the past year from the members as a whole and particularly from the members of the various committees, especially the scientific committee and the entertainment committee.

President Cloud presented the newly elected officers, as follows: Vice-president, DR. RUDOLPH C. SCHRETZMANN; secretary, DR. EDWARD V. SEXTON; treasurer, DR. FREDERICK L. MULLER; reporter, DR. HERBERT E. REINHOLD.

The president then turned the meeting over to DR. WALTER J. FARR, chairman of the entertainment committee.

Dr. Farr said that he was greatly pleased with the splendid attendance at the annual field day and installation of officers. He reported that among the afternoon games a double-header softball game had been played. Both were won by the team captained by Dr. McClain, the scores being 17-2 and 10-4.

Dr. Farr then distributed prizes among those present. The prizes were donated by the Cosmevo Surgical Co. and Becton & Dickinson.

SOCIETY FOR THE RELIEF OF WIDOWS AND ORPHANS OF MEDICAL MEN

H. A. Tarbell, M.D., Treasurer

An abstract of the annual report of the *Society for the Relief of Widows and Orphans of Medical Men* shows that during the past fiscal year there was a net gain of five members. About $5,600 in benefits was paid out to heirs of deceased members and $1,534 was transferred to the permanent capital fund. Gross disbursements during the year were $6,023. Income for the year ending May 1, 1946, amounted to $6,725. The permanent fund lent $40 to one member and gave donations to widows in the aggregate sum of $1,850. Total assets of the Society amount to over $71,000.

It is hoped that every physician in New Jersey will want to share in the work of this Society. For further information, write to the secretary, Dr. W. D. Minningham, 18 Hedden Terrace, Newark 8, N. J. Attention is also invited to the editorial appearing on page 309 of this JOURNAL.

WOMAN'S AUXILIARY — PRESIDENT'S MESSAGE

I attended the convention of the Woman's Auxiliary to the American Medical Association in San Francisco. It was inspirational, educational, and entertaining. I was impressed by the number of state presidents and delegates at meetings, and by the enthusiasm which they manifested in presenting their achievements. The knowledge I gained from the meetings was vast in scope. The various ideas for growth, both numerical and pertaining to service to the Medical Society, were unlimited. The San Francisco County Auxiliary went all out in its efforts to make visitors to the convention glad they availed themselves of the opportunity to visit their city.

Our Auxiliary is honored by the election of two of our past presidents to national office. Mrs. David B. Allman accepted the office of First Vice-President, a post which carries with it the stupendous task of Organization Chairman. Mrs. William E. Dodd, our junior past president, was elected to the Nominating Committee for the coming year.

The many fine talks I heard by prominent physicians, the constructive advice given in meetings by national officers, the warm friendliness extended our delegation by every member of the national board, gave me the assurance my trip was most successful, and above all, that it was an essential part of my office as president of the Woman's Auxiliary to The Medical Society of New Jersey.

MRS. FREDERICK G. WANDALL,
President, the Woman's Auxiliary.

BOOKS RECEIVED FOR REVIEW

Electrocardiography in Practice. By Ashton Graybiel, M.D., and Paul D. White, M.D. 2d ed. Pp. 458 with 323 illustrations. Philadelphia & London, W. B. Saunders Company. 1946. $7.00.

Synopsis of Physiology. By Rolland J. Main, Ph.D. Pp. 341, illustrated. St. Louis, C. V. Mosby Company. 1946. $3.50.

Diseases of the Adrenals. By Louis J. Soffer, M.D. Pp. 304, illustrated with 42 engravings and two colored plates. Philadelphia, Lea & Febiger. 1946. $5.50.

Preoperative and Postoperative Treatment. Ed. by Lt. Col. Robert L. Mason, M.C., A.U.S., and Harold A. Zintel, M.D. 2d. ed. Pp. 584 with 157 illustrations. Philadelphia & London, W. B. Saunders Company. 1946. $7.00.

Suggested School Health Policies; a Charter for School Health. 2d ed. pamphlet, revised by the National Committee on School Health Policies of the National Conference for Cooperation in Health Education. New York & Minneapolis, Health Education Council. 1945.

Vocational and Professional Monographs No. 65. Physiotherapy. By Thomas Francis Hennessey, M.D. Pp. 23. Boston, Bellman Publishing Company, Inc. 1946. $.75.

Campus Shadows. By H. W. Trott, M.D. Pp. 371. Hemlock, New York, Crossett & Williams. 1946. $2.75.

Diseases of the Skin for Practitioners and Students. By George Clinton Andrews, A.B., M.D. 3d ed. Pp. 937 with 971 illustratoins. Philadelphia & London, W. B. Saunders Company. 1946. $10.00.

Essentials of Clinical Proctology. By Manuel G. Spiesman, B.S., M.D. Foreword by Anthony Bassler, M.D., F.A.C.P., LL.D. Pp. 238, illustrated. New York, Grune & Stratton. 1946. $3.50.

Modern Attack on Tuberculosis. By Henry D. Chadwick, M.D., and Alton S. Pope, M.D. Rev. ed. Pp. 134. New York, The Commonwealth Fund. 1946. $1.00.

Ambulatory Proctology. By Alfred J. Cantor, M.D., with a foreword by Beaumont S. Cornell, M.D. Pp. 524, illustrated. New York, Paul B. Hoeber, Inc. Medical Book Department of Harper & Bros. 1946. $8.00.

A Malariologist in Many Lands. By Marshall A. Barber, with a foreword by Paul F. Russell. Pp. 158. Lawrence, Kansas. University of Kansas Press. 1946. $2.50.

Synopsis of Pathology. By W. A. D. Anderson, M.A., M.D., F.A.C.P. 2d ed. Pp. 741 with 327 illustrations and 15 color plates. St. Louis, C. V. Mosby Company. 1946. $6.50.

Management of Fractures, Dislocations and Sprains. By J. Albert Key, B.S., M.D., and H. Earle Conwell, M.D., F.A.C.S. 4th ed. Pp. 1322, with 1318 illustrations. St. Louis, C. V. Mosby Company. 1946.

Pneumoperitoneum Treatment. By Andrew Ladislaus Banyai, M.D., F.A.C.P., F.C.C.P. Pp. 376 with 74 illustrations. St. Louis, C. V. Mosby Company 1946. $6.50.

Textbook of Gynecology. By Arthur Hale Curtis, M.D. 5th ed. with 455 illustrations, chiefly by Tom Jones, including 36 in color. Philadelphia & London, W. B. Saunders Company. 1946. $8.00.

BOOK REVIEWS

Diseases of the Breast; Diagnosis, Pathology, Treatment. By Charles F. Geschickter, M.D., with a special section on treatment in collaboration with Murray M. Copeland, M.D. 2d ed. Pp. 826 with 593 illustrations. Philadelphia, J. B. Lippincott Co. 1945. $12.00.

With so much attention focused upon cancer, the frequent revision of a book dealing in large part with this subject is both necessary and desirable. In the two years between the editions of Geschickter's *Diseases of the Breast* much new material has become available. This has been incorporated into the new edition, and the chapters dealing with "Present Day Knowledge" and "The Mechanism of Tumor Formation" have been enlarged and rewritten.

Dr. Geschickter has reached very definite conclusions about treatment. He believes that in benign tumors, with the exception of multiple papillomata invading ducts and recurrent adenosis, the breast should be saved; that radical mastectomy is indicated in carcinoma whenever possible, and that this should be followed by adequate radiotherapy when the disease has spread beyond the breast. He sees no reason, in the evidence presented to date, to believe that estrogenic substances are the cause of mammary carcinoma in humans.

The book is written in a clear style, with the material logically arranged and easily available for reference.

Carye-Belle Henle, M.D.

Atlas of the Blood in Children. By Kenneth D. Blackfan, M.D., and Louis K. Diamond, M.D., with illustrations by C. Merrill Leister, M.D. Pp. 320. New York, The Commonwealth Fund. 1944. $12.00.

Unless underwritten by the Commonwealth Fund, it is impossible to see how a book of this caliber with the accompanying full-color reproductions of the blood cells in various diseased states could be made available for the general profession. The authors have produced a monumental work which can be read, or used as a reference by all interested in laboratory or clinical pediatrics. The accompanying text is well-rounded, concise and contains an up-to-the-minute bibliography. It will prove a valuable adjunct to any reference library.

Walter L. Mitchell, M.D.

Prescribing Occupational Therapy. By William Rush Dunton, M.D. 2d ed. Pp. 151. Springfield, Illinois, Charles C. Thomas. 1945. $2.50.

Anyone who has experienced a slow convalescence from illness or has been responsible for the care of such a person knows how recovery can be hastened by providing some form of occupation suited to the individual's capacity. Where muscular efficiency has been impaired either by disease or injury, much can be done by certain prescribed and directed activities to restore the affected parts to a wholly normal condition or to effect such a degree of improvement that the patient will be benefited physically and mentally.

In Part One of his book Dr. Dunton lists the factors entering into the administration of a program of occupational therapy and the various types of personalities to be considered in prescribing its use.

Part Two is devoted to a discussion of the application of occupational therapy to specific physical and mental conditions. In the chapter on rehabilitation its value in those cases where there has been a limitation of joint motion or a loss of an arm or a leg is emphasized. This is of special interest at this time.

Dr. Dunton's book is concise and practical. It contains many helpful suggestions as to the methods of applying the principles of occupational therapy.

Grace W. Sims, Senior Case Worker,
Essex County Welfare Board.

Cosmetics and Dermatitis. By Louis Schwartz, M.D., and Samuel M. Peck, M.D. Pp. 189. New York, Paul B. Hoeber, Inc. 1946. $4.00.

Though they are now tolerant of the use of cosmetics, many physicians know little of the composition of the various preparations. The writers, therefore, proceed to give representative types of each class of cosmetics, although they have not written a manual for cosmetic manufacturers.

Everything from antiperspirants to vanishing creams is discussed; all from a dermatologic viewpoint. The word *cosmetics* is used broadly and includes soaps and dentifrices. The history and known effects of the many types of beauty and cleaning preparations are investigated and conclusions are offered based on the experiences of the authors, and review of published literature.

Chapters are devoted to diagnosis and treatment of dermatitis, to patch testing, and to the beneficial aspects of cosmetics. The products selected for discussion include cleansing agents, emollient creams, protective creams, antiperspirants, deodorants, powders, scalp lotions and hair tonics.

The chapter on cosmetic advertising discusses the Fair Trade Practices Act of 1939, and the final chapter gives a list of certified cosmetic colors. Illustrations show some of the adverse effects of cosmetics.

The book is not only an excellent reference volume; it is fascinating reading.

Carolyn Valentine, B.S.

Cornell Conferences on Therapy. Edited by Harry Gold, M.D., David P. Barr, M.D., Eugene F. Du Bois, M.D., McKeen Cattell, M.D., Charles H. Wheeler, M.D. Pp. 322. New York, Macmillan Company. 1946. $3.25.

This ingenious volume is a collection of stenographic reports, offering, in a readable and provocative form, the authoritative opinions of forty physicians and other scientists on such variety of subject matter as use and abuse of bed rest, the doctor's bag, and Rh factor in therapy, along with discussions of specific drugs and specific diseases.

As a source of technical information, there is much to be gleaned in the spontaneous round-table discussions among the practitioners of medicine and the pharmacologists; and the verbal play of these men is sufficiently embellished with dramatic examples and imaginative presentation to make for entertaining as well as informative reading.

Two of the more provocative introductions to subjects to be considered are those of Dr. Gold on barbiturate poisoning and Dr. Dock on use and abuse of bed rest. Dr. Gold opens the question of barbiturate poisoning with the following example:

> A few days ago I asked a house officer whether he had seen a case of barbiturate poisoning during his residency. He replied that he had seen one case.
>
> "What barbiturate was it?"
>
> He said he didn't remember but that it was one of them.
>
> "How much did the patient take?"
>
> His answer was: "A bottleful."
>
> "What was the course?"
>
> "She slept a few days and recovered."

And Dr. Dock's preliminary remarks on bed rest are in part as follows:

"Man's perversions from normal mammalian or simian behavior make him the scandal of the biologic world. He not only walks erect like birds and the anthropoids, but continues to drink milk all his life, to eat eggs, and to make love at all seasons. . . . In the past century he has outdone himself with new perversions. . . . Unlike all other mammals, man sleeps on his back, and lies recumbent when ill. Until the Florence Nightingale era the sick usually got up several times daily for elimination, if not for meals; but thanks to nursing progress, thousands of people now lie recumbent, at absolute bed rest, for days, weeks, or months. As with all the other perversions from biologic normality, this too must be paid for by discomfort, invalidism, and death."

A number of the round-table discussions in the Cornell Conference were reported in the *Journal of the American Medical Association* and in the *New York State Journal of Medicine* following their inauguration in 1937 at Cornell University Medical College in New York City. Their collection into a book is commendable because it supplies in a convenient form a wealth of material which was previously somewhat scattered in periodical literature.

George Wyllie, B.S.

Nursing and Nursing Education. By Agnes Gelinas, R.N. Pp. 72. New York, The Commonwealth Fund. 1946. $1.00.

Attention has recently been focused on nursing because of wartime needs, overcrowded hospitals and a public desire to widen distribution of nursing care at lower costs. The author believes that this is the time for the nursing profession to take inventory of its resources and consider plans for the future.

To that end she seeks to answer such questions as: What are our nursing resources? How can nursing education be improved? What kinds of nurses will be needed in the next few years? What types of programs should be set up? How can standards of service be maintained?

Consideration is also given to the nursing supply and demand both before the war and in the postwar years, personnel policies, the maintenance of standards, problems of education, and the outlook and plans for the future of nursing. Recommendations are offered for improvements in nursing service and education. This monograph will interest all who are concerned with medical care and public health.

CAROLYN VALENTINE, B.S.

Treatment in General Practice. By Harry Beckman, M.D. 5th ed. Pp. 1070, illustrated. Philadelphia & London, W. B. Saunders Company. 1945. $10.00.

From the viewpoint of style, Beckman comes close to a happy medium between efficiency and readability. There is a semi-classical, charming approach to discussions, which one who appreciates good rhetoric might enjoy. In its rhetoric and readability it loses, partly, the succinctness of the more efficient phraseology of cold science. It loses its desirability as a reference book because of phrases like this. On cretinism, "Kerley writes from his wide experience, 'The required thyroid dosage is very readily learned.'" This type of sentence adds little to the substantial context. On the other hand, his section on the common cold, an elegant pitfall for empty palaver, gains by the humorous and sometimes sarcastic style of the author.

Although the book is no numbered outline, its completeness is within the average expectation, with a timely bow in the direction of a current favorite, geriatrics, on which the author gives a few well placed general and practical considerations. The deletion of treatment of the more obscure endocrine conditions is entirely justified for the reasons given in the text, but the lack of a heading for them leaves the seeker of information unsatisfied. While this is "treatment in general practice" and not an encyclopedia of treatment, a simple reference on each subject would help even the general practitioner to look further if he so desired. This reviewer can not entirely agree with the author's decision to omit all mention of Asiatic cholera, leprosy, plague, trypanosomiasis, and yellow fever. At the very least, there should have been some references for these subjects. Though these diseases are uncommon in the northern part of the country, increased plane travel between continents and the return of service men from regions harboring these disorders would have justified some mention of the treatment of these conditions.

In spite of these few shortcomings, I can think of many medical students who went to school just before the entrance of the sulfanamides on the therapeutic scene who would have welcomed a book of this sort. Increase of our therapeutic armamentarium has helped in no small way to produce this book, but an appreciation of the proper place and use of these newer drugs was equally essential to its present form, as a moderately good, but slightly inefficient reference book.

EVERETT O. BAUMAN, M.D.

Hematology for Students and Practitioners. By Willis M. Fowler, A.B., M.D. With a chapter by Elmer L. DeGowin, M.D. Pp. 499. Paul B. Hoeber, Inc. New York. 1945. $8.00.

In his preface the author writes, "This book is the outgrowth of a series of mimeographed notes on hematology combined with a collection of drawings, charts and photomicrographs used in teaching this subject to the medical students at the University of Iowa. It has been a gradual growth, incorporating those features which have best seemed to clarify the subject for the student. It is designed to meet the needs not only of the medical students but also the internist and practitioner and has been made as concise and practical as possible. It is not designed to meet the needs of, or to serve as a reference for, those who specialize in hematology."

The book can be said to follow fairly well the lines thus laid down by the author. It will fill the needs of the medical student and general practitioner adequately. More extensive works will be needed by a specialist in hematology. LOUIS GRUNT, M.D.

Nursing in Commerce and Industry. By Ethel J. McGrath, R.N. Pp. 356. New York, The Commonwealth Fund. 1946. $1.00.

This book was prepared by the National Organizatino for Public Health Nursing, under the sponsorship of Mrs. McGrath, in order that there might be an authoritative guide of the duties and responsibilities of the industrial nurse.

This branch of nursing is still young but has made remarkable progress. The book includes many of the highlights of the growth and development of this field. The author discusses the nurse's place in the industrial organization, her relationships with officers and employees, the physical facilities of the nursing service, the health education and hygiene activities of the nurse, her role in occupational and nonoccupational illnesses and accidents, records and reports, workmen's compensation, rehabilitation, and many other difficult problems.

It is a practical book and there are many pages of suggestions and advice. While it is intended primarily for the industrial nurse, it should prove enlightening to the company executive who is planning to establish a nursing service or seek more effective use of existing service. Physicians will be interested in the nursing viewpoints given.

CAROLYN VALENTINE, B.S.

Handbook of Psychiatry. By Louis J. Karnosh, M.D., and Edward M. Zucker, M.D. Pp. 302. St. Louis. 1946. C. V. Mosby Company.

Psychiatrists are insistent that their major field lies in the management of ambulatory emotional disturbances; and that the diagnosis and care of the insane are emphatically not the chief business of their specialty. If they wish to persuade the profession that this is so, this book should be carefully kept out of sight. For here is a 302-page handbook "offered with an eye to the needs of the general practitioner" (so the authors say) in which only 21 pages are devoted to the psychoneuroses of daily practice. As might be expected, these 21 pages do not give the family doctor much help. What can the practitioner do with advice like "lead the patient's interest away from his introspections into healthy constructive activities"?

Karnosh and Zucker should have confined themselves to the psychoses. On this subject, the text really makes an excellent handbook. The instructions on the examination of the patient, for instance, are intensely practical. The chapters on the management of psychotic patients, on occupational therapy, on hydrotherapy are compact, readable and utilizable. The major psychoses are vividly described. On the other hand, the stream-lined chapter on psychopathic personality and the cursory sketch of psychiatry and the law add nothing to the reader's fund of knowledge. The section on shock therapy is well prepared and up to date.

Medical Education and the Changing Order. By Raymond B. Allen, M.D. Pp. 142. New York. The Commonwealth Fund. 1946. $1.50.

"There are more applicants to medical schools than there are places in the first-year class. All of those rejected are mediocre to poor aspirants." So Dr. Allen writes—and he ought to know as he is dean of a medical school. Unfortunately almost every doctor knows of applicants who were rejected for other reasons and who were decidedly not "mediocre to poor aspirants". Then in another place, the author says, "Medical schools are in need of more good students. It is up to the high schools and colleges to provide them." To compound the reader's confusion, Dr. Allen finally concludes that "superior doctors are born not made".

The difficulty with admission requirements, the author feels, is an overemphasis on technical and science subjects in college with consequent impoverishment of the medical student's background in social sciences. For this reason he feels that "medical education shares in the responsibility for the failure of the medical profession to exhibit social insight". To meet this challenge, he advises inclusion in the college program "of such important medical science subjects as psychology, sociology, humanistic philosophy and logic".

Disposing of the premedical requirements, Dr. Allen next turns his searchlight on defects in the medical school itself. His major complaints here are that medical schools do not teach *methods* of scientific research or scientific experiment, that they neglect the study of convalescence and rehabilitation, that they do not teach "the fundamental relationships of science, medicine, law and the socio-economic system," and that they "do not consider medical education consistently from a fundamental point of view." His thesis seems to be that modern medical curicula are made up of specialties, with no effort to teach general practice. And indeed it would be a refreshing experience for a medical school to give a course in the care of patients, generally in addition to numerous courses in the care of diseases.

It would be interesting to get a medical student's reaction to Dr. Allen's remark that "a doctor must be a teacher at heart in order to educate his patients how best to care for himself. What is more natural than for a doctor to enjoy educating his students also?"

These extracts, necessarily taken out of text, do not given a fair picture of the book, though they do exhibit something of the kaleidoscopic quality of the text itself. There is a good review of the historical roots of medical education and a number of practical suggestions for overcoming the defects which the author exposes. And flowing through the entire volume is emphasis on the importance of the social and sociologic aspects of medicine.

Anesthesia in General Practice. By Stuart C. Cullen, M.D. Pp. 254. Chicago. 1946. Year Book Publishers.

If you want to send a gift to a young doctor entering his internship or to a practitioner who finds it advisable to eke out his income doing anesthesia, this manual will hit the spot. Indeed any doctor who does part-time anesthesiology or who may be called on to alleviate respiratory depression or treat shock will find this slim volume a useful addition to his library. It opens with a practical chapter on pre-anesthetic medication, including technics and dosages as well as rules for determining what premedication to use under what circumstances. It closes with a handy table of anesthetics showing indications and contra-indications. In between are sections on the maintenance of the airway, the signs of anesthesia, the recognition and treatment of shock, explosion hazards, postanesthetic care, the determination of the choice and method of anesthesia, and for each anesthetic, a chapter on technics, indications, and contra-indications. The text is enlivened by a half-dozen humorous cartoons which deliver their lessons with a potent punch. It is the job of the anesthetist to bring the patient beyond the threshold of consciousness, almost to the very frontier between life and death; and then to bring him back: a job not to be undertaken without study and preparation. Here is a book which will make the study pleasant and preparation effective.

Tuberculosis Abstracts

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XIX **August, 1946** **No. 8**

WHEN the private physician makes a diagnosis of tuberculosis and succeeds in getting a patient under sanatorium care, he is apt to feel that his job is done. If that patient leaves the sanatorium prematurely, his physician will be handicapped in his subsequent efforts by the failure of this first hospital experience. A knowledge of some of the factors that lead tuberculous patients to leave hospitals against medical advice should help physicians to prepare patients for accepting and completing hospital care.

THE SIGNING OUT OF TUBERCULOUS PATIENTS

Those who are interested in helping a patient to use the medical care necessary for recovery and to accept a possible physical limitation, find challenging problems in work with the tuberculous. The importance of this may be realized when hospitals in different parts of the country report that from 22 to 65 per cent of their patients leave "At Own Risk (A.O.R.)."

The patients who refuse all treatment have not been considered. The focus has been on patients who have evinced a desire to get well but who during the course of treatment attempted to terminate their recovery process. All hospital personnel, including the social worker, must accept "It is never the body only which is out of health, but always the complete being." Often the reasons for leaving the hospital are obscure and great skill is needed to help the patient to be realistic and to direct himself toward the goal of complete recovery.

The treatment and hospitalization of patients with tuberculosis involves months or years of restricted activity. A young athletic boy, suddenly faced with tuberculosis, may revolt at accepting this state. Since the tubercle bacilli carry on their destructive work insidiously, the patient, after he has regained some strength, will insist that his cure is completed. This view is maintained despite the contrary evidence of X-rays and sputum reports. Perhaps the fear of the disease is so great as to cause the patient to reject its reality.

The older man and woman, accustomed to years of labor in factory and home, may also find it difficult to accept the new role of inactivity and dependency. Experience has not fitted them to fill the passing empty hours. The thought of lying quietly in bed while the world hurries on is untenable and they are tortured by the desire to be back among the working multitudes.

This boredom is more readily conquered by patients accustomed to study or reading, or those who are fortunate enough to have a hobby. Hospitalization is a difficult experience for the majority, but it can be a constructive one. Rarely does a patient who has found activities that lead to growth and development, sign out against advice. There is also a distinct difference between those patients who have made their adjustment and those who have succumbed to the sheltered life of the hospital and have regressed to an infantile, dependent level.

There does not appear to be any constant point at which a patient may feel that the hospital is no longer bearable. Even when individuals may be apparently adjusted to the hospital routine, the inactivity may lead to cumulative effects until a breaking point is reached. A little supportive treatment at this time will often tide the patient over the rough spot.

An individual entering a hospital brings with him the sum total of his life experiences. He has certain ties, certain obligations, and these remain though they are altered by the new experience. Early contact with the patient and his family can give clues to the patient's motivations and the part the family will play. The marital strengths, the interfamily ties and strains, the relationships in a

changing setting should all be weighed and evaluated with the patient. The patient must, if possible, be spared the worry and anxiety of the family. This cannot be done by simply hiding or ignoring real problems. If the family is aware of this, they can show the patient their strengths in meeting problems and assure him that they can keep their balance.

The social worker is often faced with a recently admitted patient who demands to leave the hospital with or without the doctor's permission. An interview usually begins with the patient demanding "How can I remain here while my family starves?" The social worker can be of invaluable aid in directing the family to sources of help and thus make it possible for the patient to accept his hospital stay knowing that his family will not starve or go homeless.

Life in a hospital is complex. A patient is faced with the need to adjust to his companions, the doctors, nurses, and other personnel. He has to give up practically all his privacy, both physical and mental. There are new ideas to be adjusted to in this microcosm of all nations and races. It is not difficult for friction to arise between the patient and a particular person or routine. Personalities may clash and the sick person may feel that the only solution lies in leaving the hospital. Sometimes the patient does not indicate the real reason for signing out but gives the usual statement that he "can do just as well at home." Other patients are quite verbose regarding the sources of annoyance.

All members of the hospital team can play very important parts in helping the patient adjust, not only to his illness but to the hospital life. A healthy adjustment in the hospital implies a psychological awareness and acceptance of the illness. When the acceptance has not been achieved, the patient rejects the hospital as a symbol of the disease. In the adjustment of the patient to the hospital one factor that might be given special attention is the food. Tuberculous patients are very conscious of the role of food in their cure and of the variations in their weight. This is one of the chief topics of conversation. One director of a sanatorium when asked how he kept down his A.O.R. discharges to a surprisingly low figure replied that he gave the patients the type of food they would get in their own homes.

An analysis (such as this abstract) cannot give all the reasons why patients interrupt the treatment process. The individuality of every situation is marked, and therein lies the challenge. The problem is a big one. There has been a constant war against tuberculosis. In its earlier stages this fight was on a mechanical level of cleaning up slums, taking mass X-rays, or providing the proper type of hospital care. But now we have come to realize that we are dealing with human beings and the control of the disease will come only when the sick person is prepared to participate.

The Signing Out of Tuberculous Patients, Jean Berman and Leo H. Berman, The Family, April, 1944.

SUPPLIED BY

New Jersey Tuberculosis League

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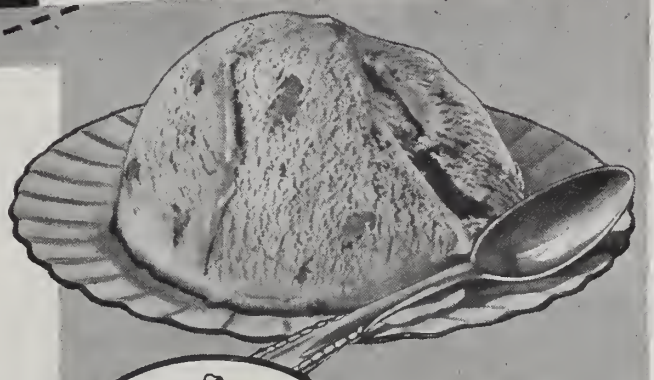
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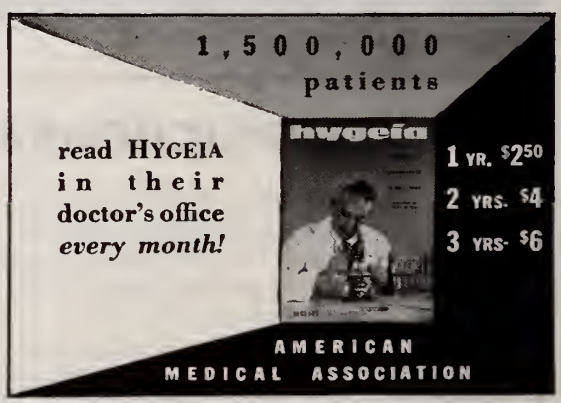
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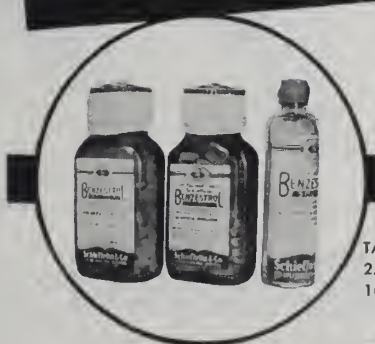
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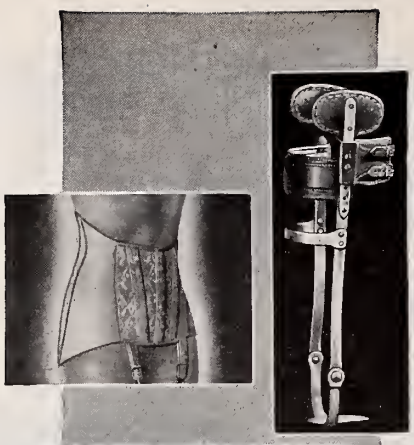


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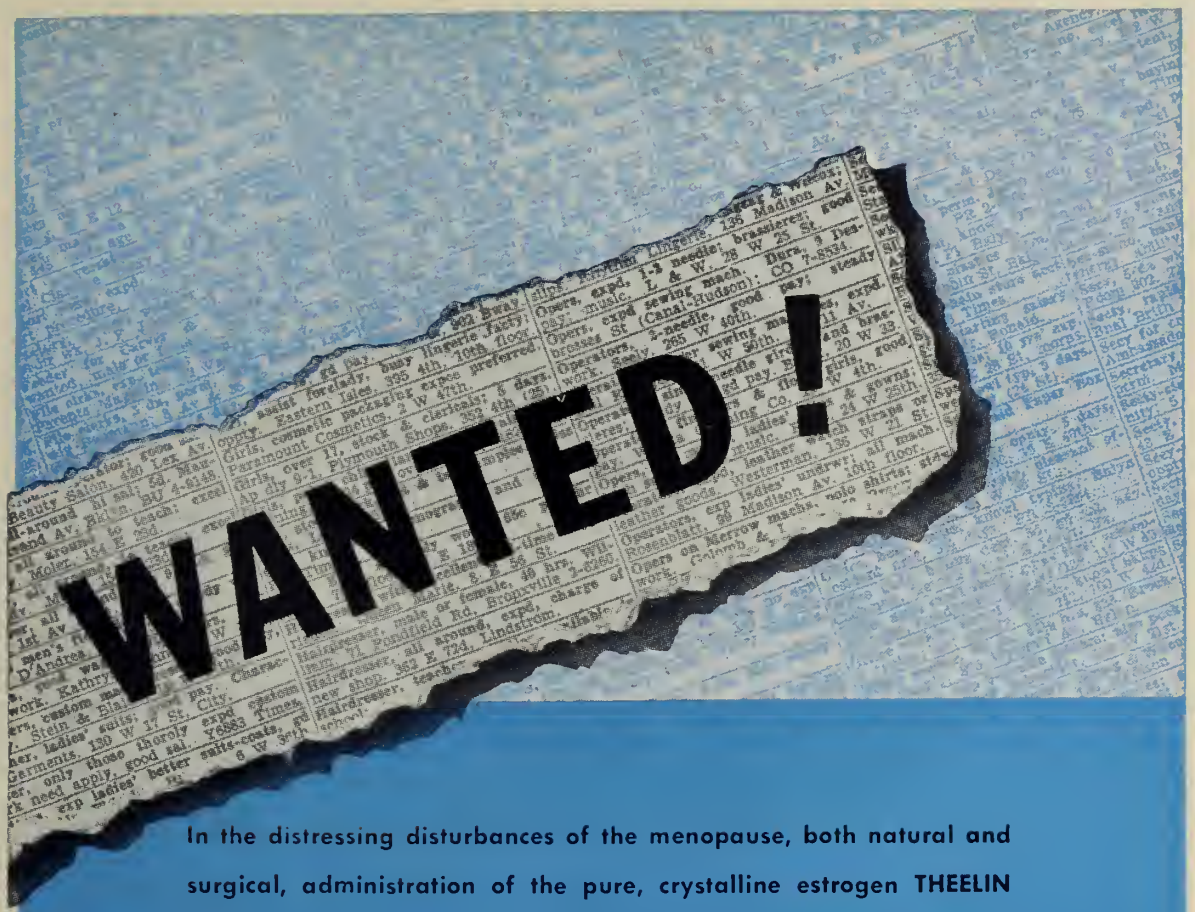
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Issued as a Supplement to The Journal of The Medical Society of New Jersey, August, 1946

MINUTES OF THE HOUSE OF DELEGATES

Tuesday Morning Session—May 21, 1946

The First Session of the House of Delegates of the One Hundred and Eightieth Annual Meeting of The Medical Society of New Jersey convened in Cambridge Hall, Claridge Hotel, Atlantic City, New Jersey, at 11:10 o'clock, Dr. Samuel Alexander, of Park Ridge, President of the Society, presiding.

PRESIDENT ALEXANDER: The One Hundred and Eightieth Annual Meeting will come to order. Secretary Stahl, is there a quorum present?

SECRETARY STAHL: There is.

PRESIDENT ALEXANDER: Members of the House of Delegates: We meet here today for our One Hundred and Eightieth Annual Convention. The last meeting of our House of Delegates took place in 1944. A great deal has happened since. The war is over. Our men are returning back to civilian life, and at this time I want to extend a hearty welcome to those who served in the armed forces in this last war.

I hope the Delegates will take an active interest in the work of the convention. We have tried hard to give you what we think is an excellent program. The business sessions we must have. We have tried to set up a social program that I am sure you will all enjoy. The Scientific Committee has organized an excellent program, and I hope that all the men and women who attend the convention will find time to partake in at least one scientific session. The scientific sessions will be held tomorrow, the banquet tomorrow night. General Hawley will be our guest speaker, and those of you who have heard him before can appreciate what a splendid speaker he is and what a message he will have for us.

At this time I appoint as Parliamentarian for the business sessions, Dr. Frederic J. Quigley.

The Reference Committees have been appointed, and they are listed in your programs.

The minutes of the 1944 Annual Meeting were published in the JOURNAL, August 1944 issue. Are there any corrections or omissions?

DR. CHESTER I. ULMER: I move that they be approved as published.

DR. HENRY C. BARKHORN: Seconded.

(The motion was put to a vote and was carried.)

PRESIDENT ALEXANDER: The minutes of the 1945 Annual Meeting were published in the July 1945 JOURNAL. Are there any omissions or corrections?

DR. ULMER: I move that they be approved as printed.

(The motion was regularly seconded, was put to a vote, and was carried.)

PRESIDENT ALEXANDER: The President's Annual Report was printed in the May JOURNAL. He has no supplementary report. It will be referred to Reference Committee A. The Annual Report of the Board of Trustees will be found on page 180 of the May JOURNAL. Has Dr. Norton, Chairman of the Board, any supplemental report?

DR. NORTON: I have.

PRESIDENT ALEXANDER: We are ready to hear it now.

DR. NORTON: The following recommendations were unanimously approved by the Trustees at their meeting on May 20. With reference to the Veterans Medical Care Program, the Trustees hereby recommend:

1. That there be appointed by Medical Service Administration one or more coordinators from the membership of The Medical Society of New Jersey, with the approval of the Board of Trustees of The Medical Society of New Jersey.
2. That this coordinator or these coordinators be selected and paid by Medical Service Administration.
3. That in order to procure the necessary funds incidental to the operation costs of Veterans' Care Program and to underwrite the cost of a coordinator, a special assessment of $15.00 be levied against each member of The Medical Society of New Jersey for the ensuing year.
4. That this assessment shall be due and payable on July 1, 1946.
5. That Medical Service Administration be officially designated as The Medical Society of New Jersey's corporate body in all negotiations with Veterans Administration.

PRESIDENT ALEXANDER: This will be referred to Reference Committee A. Has the Judicial Council any report supplementary to the one which appeared on page 181 of the May JOURNAL? I hear none. The report of the Judicial Council is referred to Reference Committee A. Does the Treasurer have any supplementary report?

DR. YOUNG: I have.

DR. ALEXANDER: We are ready to hear it now.

DR. YOUNG: This is our Treasurer's Report for the year 1945-1946. On June 1, 1945, we had a balance of $75,362.20. Last week, on May 15, 1946, we had a balance of $80,789.34. Our net receipts for the year were $161,725.62, as follows:

RECEIPTS

(June 1, 1945 - May 15, 1946)

Balance, June 1, 1945		$ 75,362.20
Assessments:		
Atlantic County	$ 1,720.00	
Bergen County	4,080.00	
Burlington County	1,020.00	
Camden County	2,666.00	
Cape May County	400.00	
Cumberland County	980.00	
Essex County	17,659.00	
Gloucester County	744.00	
Hudson County	7,519.00	
Hunterdon County	506.00	
Mercer County	3,420.00	
Middlesex County	2,380.00	
Monmouth County	1,982.00	
Morris County	1,766.00	
Ocean County	340.00	
Passaic County	5,650.00	
Salem County	420.00	
Somerset County	986.00	
Sussex County	400.00	
Union County	5,504.00	
Warren County	644.00	
		60,786.00
Interest		316.29
Sale of Maternal Welfare Books		136.00
Revenue Unexpected		17.50
Commercial Exhibits (net)		3,328.44
Journal Advertising (net)		21,776.69
Scientific Research Fund Interest		2.50
Net Receipts		$161,725.62

During the year, our disbursements amounted to $80,936.28, as follows:

BUDGET ACCOUNTS

(June 1, 1945, to May 10, 1946)

A- 1—Acting Executive Officer Salary	$ 916.66
A- 2—Executive Office Salaries	5,760.00
A- 3—Executive Office Expenses	1,154.46
A- 4—Executive Office Travel	516.11
A- 5—Permanent Home Operating Exp.	4,163.12
A- 6—Treasurer	38.05
A- 7—Finance and Budget Committee	29.82
A- 8—Bonding	85.00
A- 9—Audit	325.63
A-10—Secretary	1,540.11
A-11—Salary Taxes	257.25
A-12—Insurance	241.73
B- 1—Journal Publication	15,571.64
B- 2—Journal Cuts	81.93
B- 3—Editor's Salary	833.33
B- 4—Editorial Office Salaries	2,160.00
B- 5—Editorial Office Expenses	400.20
B- 6—Journal Travel	20.16
C- 2—Welfare Committee	718.22
C- 3—Legislative Committee	3,400.28
C- 4—Public Health Committee	792.03
C- 5—Public Relations Committee	2,927.08
C- 6—Medical Practice Committee	219.67
D- 1—President	1,197.52
D- 2—A. M. A. Delegates	671.76
D- 3—Conference Dues	50.00
D- 8—Woman's Auxiliary	975.00
D-11—Medical Service Administration	10,048.66
D-13—Post-Graduate Education Committee	52.32
E —Contingent	1,693.75
H —Pension	1,375.00
	$ 58,216.49
Salary Taxes Withheld	250.08
	$ 57,966.41
1944-45 Accounts Payable	2,490.10
Veterans Care Plan	10,000.00
Remission of 1945 Dues	88.00
Permanent Home Renovations and Equipment	10,391.77
Net Disbursements	$ 80,936.28
Cash Balance, May 15, 1946	80,789.34
	$161,725.62

Our Permanent Capital Fund is $15,065.25 and is accounted for as follows:

PERMANENT CAPITAL FUND

	May 31, 1945	May 15, 1946
Cash	$ 1,701.81	$ 2,634.06
U. S. Savings Bonds	10,500.00	10,500.00
U. S. Treasury Bonds	1,022.97	1,022.97
Investors Mortgage and Realty	1,038.25	468.25
Trenton Mortgage Service Company	802.22	439.97
	$15,065.25	$15,065.25

KIPP MEMORIAL FUND

Eye, Ear, and Throat Section

	May 31, 1945	May 15, 1946
Howard Savings Institution, Cash	$ 38.90	$ 38.90

SCIENTIFIC RESEARCH FUND

	May 31, 1945	May 15, 1946
Cash	$ 13.75	$ 16.25
Government War Bonds	300.00	300.00
	$ 313.75	$ 316.25

PRESIDENT ALEXANDER: This will be referred to Reference Committee B.

DR. DAVID B. ALLMAN: Dr. North has asked me to present this proposed budget for 1946-47:

BUDGET FOR 1946-1947

A- 1—Executive Officer Salary	$10,000.00
A- 2—Executive Office Salaries	10,400.00
A- 3—Executive Office Expenses	1,200.00
A- 4—Executive Office Travel	800.00
A- 5—Permanent Home Operating Expenses	5,300.00
A- 6—Treasurer	150.00
A- 7—Finance and Budget Committee	50.00
A- 8—Bonding	85.00
A- 9—Audit	330.00
A-10—Secretary's Office	2,000.00
A-11—Salary Taxes	495.00
A-12—Insurance	425.00

B- —Journal Advertising Receipts	$28,950.00	
B- 1—Publication	$18,500.00	
B- 2—Cuts	150.00	
B- 3—Editor's Salary (part-time)	2,500.00	
B- 4—Editorial Secretary Salary	3,000.00	
B- 5—Journal Office Expenses	500.00	
B- 6—Travel	200.00	
B- 7—Commissions, Discounts	4,100.00	
	$28,950.00	
C- 2—Welfare Committee		800.00
C- 3—Legislative Committee		7,000.00
C- 4—Public Health Committee		1,000.00
C- 5—Public Relations Committee		7,000.00
C- 6—Medical Practice Committee		1,000.00
D- 1—President		2,500.00
D- 2—A.M.A. Delegates to San Francisco		1,715.00
D- 3—Conference Dues		100.00
D- 8—Woman's Auxiliary		1,600.00
D-11—Medical Service Administration		12,150.00
D-13—Post-Graduate Education Committee		250.00
E —Contingent Fund		3,000.00
F —Legal		1,000.00
G —Annual Meeting Exhibit Receipts	$ 5,000.00	
Expenses	5,000.00	
H —Pension		1,500.00
Total		$71,850.00

The Finance and Budget Committee makes the following recommendations:

1. That the per capita assessment for 1947 be $20.00;
2. That the policy of The Medical Society of New Jersey to give a dues credit to members in service be continued for 1947 dues; and
3. That members separated from service after October 1, 1946, be given a dues credit for 1947.

President Alexander: The Supplemental Report of the Finance and Budget Committee will be referred to Reference Committee B.

Dr. Henry B. Decker: This is the report of the Committee on Post-Graduate Education:

During the past year your Committee on Post-Graduate Medical Education has continued and completed negotiations with Rutgers University for the establishment of a graduate course in hospital dispensaries for continued training of general practitioners.

Rutgers University will supervise and administer the course and at its satisfactory completion will issue a certificate to the student. This certificate will carry the seal of the university and the signature of its president.

The course will require attendance at a dispensary twice weekly for a period of three years, and a weekly conference plus a monthly seminar.

The three years will be divided into twelve quarters of three months each. Four quarters will be spent in general medicine, two quarters in midwifery, one each in surgery and pediatrics and the remaining four in the specialties.

This is a new adventure in medical education. Many changes will undoubtedly be made before it is perfected. Because of this it is felt best to start in one hospital and the experience gained there will make it easier to expand in other hospitals.

Negotiations with the Cooper Hospital in Camden are completed and it is expected that the course will start there during July, 1946.

Two students will be admitted each quarter. The first group of students will be carefully selected for their ability to constructively criticize. This is done on the advice of authorities at Rutgers University.

Rutgers University will carry the students on their rolls and the instructors will be listed as faculty members of the university.

Your committee feels that this effort be continued education will, in the next few years, bring forth better care for the patient and better training for the practitioners and hospital staff member.

President Alexander: The report and the supplemental report are referred to Reference Committee D.

Subcommittee Reports, pages 188 to 192 of the May Journal, referred to Reference Committee E. Has Dr. Pollak, Chairman of the Legislative Committee, any supplemental report?

Dr. B. S. Pollak: I have. This is not a supplemental report. This is a report of the Committee on Legislation, inasmuch as our committee felt that there were so many matters under consideration that we could not give the report in advance.

It is with a sense of satisfaction and considerable relief that this report is made. It is not an overstatement to say that this has been a busy year legislatively, especially in state legislation.

As this year's session of the State Legislature opened we were immediately confronted by two bills which would have made possible the licensure of graduates of unapproved medical schools. Senate 95 was exclusively in the interests of medical veterans who were residents of this state. Assembly 45 would have permitted graduates, whether veterans or not, to take the examination for licensure. Neither of these bills passed. Senate 95 was withdrawn March 25th and Assembly 45 was defeated in the Assembly April 9th.

Failure of passage of these two bills is ascribable in the main to the fine work done by the Legislative Keymen of the County Societies and the support of the County Society officers and members, especially the veterans of this war and their wives. The Woman's Auxiliary in several of the counties also rendered excellent service in opposing these bills.

The next measure deserving discussion is Assembly 47—reorganizing the State Department of Health. We think that the Delegates are fairly familiar with the main features of this bill and with the verbal spanking administered to the profession by the Governor immediately following its defeat. We hope that the membership read the excellent reply by President Alexander to the unwarranted disparagements by the Governor.

It serves no useful purpose to go into extended discussion of the work actually done by the committee on this bill. Originally, the Public Health Council provided by the bill was to have consisted of seven individuals possessing no professional quali-

fications. Subsequently the measure was amended in the Assembly to provide that two of the seven members should be physicians. However, it was the considered opinion of our Legislative Committee and the allied professions that the Council should consist in the main of persons of professional competence in the health field. Our point of view appealed to the Senate and the bill, after reaching this body, was amended so as to provide for a Council of nine, seven of whom should be representatvies of the medical and allied professions, and two from the public at large. Failure of the Assembly, in the closing half hour of the session, to accept the bill as amended by the Senate was the cause for its failure of passage.

It is not our purpose to report upon all the bills which we followed during the session, and upon which we took definitive action, but a few, we think, are deserving of mention in this report.

Assembly 171, which would have set up four cancer clinics in the state, with an appropriation of $250,000 for this purpose, was defeated. As the result of strong emotional appeal this measure passed the Assembly, but upon reaching the Senate was referred to the Appropriations Committee where it remained. Our opposition to this bill was motivated by the fact that there is at the moment insufficient factual data upon which to make intelligent recommendations as to increased facilities for cancer control. As a result of the initiative of the Society's Advisory Committee on Cancer Control, a survey sponsored jointly by this advisory committee, the State Department of Institutions and Agencies, the State Department of Health and the New Jersey Division of the American Cancer Society was undertaken and is now underway. When this survey is completed, as well as the more comprehensive hospital survey now being conducted by the Commission on Post War Economic Welfare, we should be in a position to know what additional facilities for cancer are needed.

Our experience with this bill convinces us that not only are the Legislators greatly interested in any proposal for cancer control, but that the laity, generally, is also.

The passage of Assembly 164 places a chiropodist on the State Board of Medical Examiners. The chiropodist member shall have equal rights and privileges in chiropody matters *only* and shall not have the right of vote in the election of officers of the board.

Senate 120, sponsored by the Department of Institutions and Agencies, which passed the legislature and has been signed by the Governor, is a most interesting measure. This bill permits the State Board of Control of Institutions and Agencies to establish a diagnostic center for mental and physical examination of persons committed to the custody of this department, and permits courts to utilize this center in advance of sentencing defendants. Passage of this bill would seem to be a logical and progressive step in the scope of function of the Department of Institutions and Agencies.

The signing of a contract by the Medical Service Administration with the Veterans Bureau, to provide medical care of veterans with service-connected disabilities by their physician of choice, made necessary the passage of a bill (Senate 278) amending the Medical Service Corporation Act, to permit the Medical Service Administration to contract with the Veterans Bureau for hospital care incident to the medical care of veterans.

Two bills which failed of passage, Assembly 133 and Assembly 219, are of especial interest to members of the Society engaged in eye work. Both of these measures were referred to the Committee on Miscellaneous Business, commonly referred to as "the morgue". The first of these bills (A-133) would have forbidden any discrimination on the part of bodies, such as boards of education, as to ocular reports by physicians or optometrists, and the second measure (A-219) would, among other things, have permitted optometrists to fit contact lenses.

Assembly 91, creating a separate board of chiropractic examiners, and Assembly 183, creating a separate board of naturopathic examiners, were referred on April 2nd to the Committee on Miscellaneous Business.

Senate 121 broadens admission of tuberculous cases to the State Sanatorium at Glen Gardner, by allowing acceptance of advanced cases.

The last subject under state legislation which we shall discuss might well serve as the introduction to our subsequent remarks regarding federal legislation.

It will be recalled that in the five-point health program which President Truman proposed to the Congress November 19, 1945, the fifth point was cash sickness and disability benefits for employed workers. As a result of the recommendation of Governor Edge in his inaugural message, there was created, by act of the Legislature, the New Jersey Commission on Post War Economic Welfare. The composition of this commission is of such character as to commend it to the citizens of the state. In response to Assembly Concurrent Resolution No. 3, passed by the 1946 Legislature, this commission was directed to make a study of the establishment of an "Unemployment Sickness Compensation Fund" and a "System of Unemployment Sickness Compensation Benefits" in this state. A hearing on this subject was held before the Commission on March 8th. At this hearing the Executive Secretary of this committee, Dr. Quigley, presented a statement in support of the principle of cash sickness benefits. It should be recalled here that the American Medical Association, at a special meeting in 1938, went on record in favor of this principle. The statement submitted by the Executive Secretary of this committee, in advocating support of the principle of cash sickness benefits, suggested that the voluntary plans—and there are a great number of them—now in effect be utilized and extended, but that it be made obligatory upon the part of industry not carrying such plans, either to set up a satisfactory plan of cash sickness benefits, or insure their employees, to compensate partially for the financial loss incurred during periods of sickness or disability.

The only organization appearing in opposition to the principle of this proposal was the New Jersey Manufacturers' Association. The New Jersey State Chamber of Commerce favored the principle but opposed the creation of a "state operated system" and strongly advocated utilization of existing voluntary plans.

The Commission on Post War Economic Welfare, on April 9th, issued its report on cash sickness benefits and included in it three suggested bills to make available cash sickness benefits to employed workers. These bills were introduced *for study only* in the last week of the Legislature. The report of the commission on this subject is a most interesting one and the method of approach to this problem might well serve as a pattern for other states. For those who may be interested in the report we suggest that they write for a copy to the secretary of the commission, Mr. Milton Mann, State House,

Trenton. It is almost certain that bills to put into effect cash sickness benefits will be passed at the 1947 session of the Legislature.

Fairly constant contact is maintained with the American Medical Association, especially with the Bureau of Legal Medicine and Legislation. In connection with several pending bills we have been asked by the Bureau to either write or wire committees of Congress or the New Jersey members with respect to the attitude of organized medicine on these measures.

As you are aware, hearings on Senate 1606, the new Wagner-Murray-Dingell Bill, have been in progress since the beginning of April. The Executive Secretary of this committee, Dr. Quigley, attended the hearings in Washington on the 17th and 18th of April. On the 17th the representatives of the American Medical Association presented their point of view. We understand that the Chairman of the Board of Trustees, Dr. Sensenich, made a particularly good witness and withstood all efforts on the part of the chairman of the Committee on Education and Labor, Senator Murray, and Senator Pepper, to have him admit or agree that certain of the ideas of Title II—compulsory sickness insurance —were desirable.

With respect to this bill and President Truman's program the consensus of thought of organized medicine throughout the country seems to be that we favor increased hospital and public health center facilities. The Hill-Burton Hospital Construction Bill, to accomplish these purposes, has, as you know, passed the Senate and hearings before the committee of the House of Representatives have been completed. Action by that body is now awaited.

There is general agreement that the purposes of Title I of S-1606, to provide for the extension of public health services and for maternal and child health care, are desirable objectives, *where the need is shown and financial inability of a state to meet this need unaided is demonstrated.* So that this portion of the bill, with changes in language, could be made acceptable to the profession.

The section of the bill providing for "medical care of needy persons" is deserving, we think, of thoughtful consideration by our Welfare Committee, especially the Subcommittee on Medical Practice. In this connection we offer this idea for consideration: In view of the fact that the State Commission on Post War Economic Welfare is now conducting a survey to determine the adequacy of hospital and public health facilities in the state, and has just rendered an excellent report with respect to cash sickness benefits, it might be desirable to suggest to this commission the advisability of making a study of possible improvement of the medical care of the needy, and the feasibility of setting up a state program adaptable to the various municipalities of the state.

Whether the Senate Committee on Education and Labor reports the Wagner-Murray-Dingell Bill (S-1606) favorably or not, from all available information, we do not believe that the measure as presently written will pass at this session of the Congress.

On May 3rd Senator Taft of Ohio (for himself, Senator Smith of New Jersey and Senator Ball of Minnesota) introduced Senate 2143, a most interesting and important measure, in our opinion. The language of the bill is refreshingly clear and direct, and, apparently, no sections are in conflict with others. While all of the several provisions are important, the measure has two major purposes:

1. The creation of a National Health Agency, into which would be placed all the presently scattered health agencies of the Federal Government, including the Public Health Service and the Children's Bureau.

2. Federal aid to states which establish plans to provide, within five years, adequate medical, dental, and hospital services "for families and individuals with low income".

A summary of this bill has been prepared for the information of the House of Delegates, and is now available. May we suggest a reading of this summary, if possible, before the final meeting of the House on Thursday, so that definitive action may be taken on this bill at that time, if such action is deemed advisable.

The ever increasing interest on the part of civic (lay) groups in public health legislation in this state and in the nation convinces us of the absolute need for expanding our public relations work so that the public will have a clearer understanding of what actually *is* needed for improvement in the distribution of medical care, what is now being done by organized medicine to this end, and what further steps are being considered.

This report would be incomplete if I failed, as chairman of this committee, to make acknowledgment of the contribution made by all members of the committee. That they have taken the work of the committee seriously is evidenced by the uniformly fine attendance at all meetings. The Executive Secretary wishes to acknowledge—and in this I join—the ever ready and intelligent cooperation given by the Acting Executive Officer, Mrs. Madden, and the very capable secretarial assistance of Miss D'Arcy of the Executive Office. Finally, I desire to emphasize the excellent methods pursued by Dr. Frederic J. Quigley that have been in a large measure responsible for the results that have been attained, and, as in years past have crowned his efforts with success.

A postscript is necessary because of information received only yesterday (Monday, May 21). It will be recalled that last July Senator Pepper, for himself and nine other members of the Senate, introduced S.-1318, a bill to provide obstetric services to all mothers and medical care of all children until the age of 21 years, regardless of ability of pay for such services. The companion bill to this measure was introduced by Congressman Mary T. Norton, H. R. 3922. We are advised that hearings have been called starting May 28 on this bill—H. R. 3922. A subcommittee of the Committee on Labor: the Subcommittee on Aid to the Physically Handicapped, of which Congressman Kelley of Pennsylvania is chairman, will conduct the hearings.

The American Medical Association will be represented at the hearing in opposition to the bill. It is recommended that this House of Delegates adopt resolutions in opposition to this bill.

President Alexander: A very fine report! It will be referred to Reference Committee E.

Dr. Nichols, Chairman of the Public Health Committee, have you any supplemental report?

Dr. Nichols: Yes, Mr. President. I am presenting a supplementary report with additional recommendations because the administration has allowed me to return to the promotion of better child health by this Society. This is both my vocation and my avocation. I have served the Public Health Committee here for fifteen years as secretary and chairman of the committee.

During these fifteen years, our committee has steadily kept pace with the rapid expansion of public interest in many public health services as well as increasing participation with both voluntary and official agencies in various aspects of health promotion and disease control. To the original child health responsibilities of the committee have been added in rapid succession the problems of Maternal Welfare, School Health, Crippled Children, Mental Hygiene, Conservation of Vision and Hearing, Tuberculosis, Venereal Diseases, Cancer Control, Nutrition, Cardio-Vascular Disease, Adult Health Supervision, and last, but not least, Tropical Diseases resulting from the recent war.

Largely due to the fact that the members of this Society, who were medical leaders in each of these fields, promptly and without exception, during all these years, accepted appointments on these fourteen advisory committees and worked with diligence and wisdom on their committee problems, our Society has been able to keep the medical profession of this state in its proper position as hearty cooperators and constructive leaders in every old and new public health field. It is not just a happenstance that every health movement that is begun in this state confidently looks to The Medical Society of New Jersey for aid and assistance, but this fact is due to the untiring service of the state and county health committeemen who have contributed unstintedly of their time and efforts through the years.

Over 700 members of this Society have, at one time or another, served on our state and county public health and advisory health committees, and this Society owes each a debt of gratitude for his long and faithful service in this health field so vital to the future practice of good medicine in the public interest.

I wish to take this opportunity to express my personal thanks and appreciation to all chairmen and members of the state and county health committees, whose prompt and able acceptance and performance of committee assignments have made serving this Society in this capacity a privilege and a pleasure. My faith in the willingness of our medical profession to shoulder any and all public health responsibilities and do a good job in that connection is based on this experience in the field.

In the light of this experience, may I be permitted to offer for the good of the Society two additional recommendations which could be of great service toward the never ending task of this Society which involves the continuous integration of the private practitioner of medicine into the public health fields.

First recommendation: That a full time executive secretary, preferably a person with some administrative experience in one of these public health fields, be provided the incoming Chairman of the Public Health Committee and the chairmen of the fourteen advisory committees. (The time has long since passed when any practicing physician, no matter how interested, can cover the needs adequately of these fourteen committees. Several of these fields are to expand greatly during the coming year.)

Second recommendation: Now that most of our members have returned from service in the armed forces, it is recommended that all county societies reconstitute their public health committees and in large county societies, where possible, replicas of the fourteen state health advisory committees, as the coming year will need a great deal of activity at county levels on the part of county societies to keep pace with the tremendous interest in public health and medical care that has grown so rapidly in recent years.

In conclusion, let me state that it has been a great privilege to serve this Society in this capacity during these years and to bespeak for my successor the same gracious and willing response on the part of every member of the Society that has served to so wonderfully lighten our burdens on the uphill public health road, which all organized medicine in this country is, at long last, now traveling with us.

PRESIDENT ALEXANDER: The Public Health Supplemental Report will be referred to Reference Committee E.

PRESIDENT ALEXANDER: Dr. Scammell, our President-Elect! Dr. Scammell, won't you come up to the head table? (Applause.)

DR. CHARLES H. SCHLICHTER: Your Committee on Intern Training, realizing the extreme importance to the hospitals of New Jersey of the present shortage of interns, is of the opinion, that a joint committee composed of members of the New Jersey Hospital Association and members of the State Medical Society be created and that this committee make an exhaustive study of the whole intern situation as it affects New Jersey hospitals. There is much to be learned by such a study.

PRESIDENT ALEXANDER: Are there any resolutions or memorials to be introduced at this session?

DR. MARCUS W. NEWCOMB: *"Resolved, That the matter of tuberculosis control of migrant labor in this state be referred to the Advisory Committee on Tuberculosis and to the Subcommittee on Legislation for appropriate action."*

Migrant labor, especially in the rural counties in South Jersey, is a serious problem, and we are introducing many foreign tubercle bacilli from the South and from Jamaica. In our county we have had patients with far-advanced, active tuberculosis who have been in New Jersey only two or three months. If these laborers would be x-rayed before they are sent out on the farms, we could detect the advanced cases before they have a chance to spread tubercle bacilli through our state; this is an important question and it should be given consideration because in South Jersey and some parts of North Jersey, there are many thousands of these migrant laborers.

I should like to see this referred to the appropriate committee for action. At present it appears that no governmental agency has authority to make rulings concerning tuberculosis among migrants. It seems to me then, that we—The Medical Society of New Jersey—should take some action.

PRESIDENT ALEXANDER: Dr. Newcomb's resolution is referred to the Reference Committee on Resolutions and Memorials. Are there any amendments to the Constitution or to the By-Laws offered at this time?

DR. SCHAAF: Mr. President, three such amendments are here offered. The first comes from the Hudson County Medical Society and reads as follows:

The Hudson County Medical Society has instructed its delegates to ask for a change in Section 2(d) of the By-Laws, which now reads:

"The Official List as published each year shall be *prima facie* evidence of the right of members to register at the Annual Meeting; and unless otherwise ordered by the House of Delegates shall form the basis of representation of each component society."

It is proposed to add to this the following clause:

". . . except that after the Official List is printed, any component society which finds that it is entitled to additional delegates and alternates may elect these at its April or May meeting."

I ask that this be referred to the Committee on Constitution and By-Laws. Next is a proposed change in Article IV, Section 5, of the Constitution. It is proposed that this be amended to permit eminent persons who are not physicians to be elected to Honorary Membership. Accordingly it is proposed that Section 5 of Article IV be rewritten to read:

"Honorary Members shall be physicians and surgeons who have attained distinction within the medical profession, or nonmedical persons who have rendered signal service to The Medical Society of New Jersey, or who have attained special eminence in scientific fields other than medicine. Honorary Members may be elected by a two-thirds vote of the House of Delegates after having been recommended by the Committee on Honorary Membership; provided the number of living Honorary Members does not exceed fifteen. Honorary Members shall have all the privileges of Members but shall not be members of the corporate body."

The idea is that we may thus honor certain persons who have done a great deal for the Society. Particularly, we have in mind Mr. John S. Thompson, who has been a member of the Board of Medical Service Administration, and who has rendered invaluable service in the actuarial side of the Medical-Surgical Plan and the Medical Service Administration. Without his finanical and actuarial guidance, the plan might well have been in financial difficulties many times, and the Medical Service Administration was eager to have Mr. Thompson honored, if it could be done.

I would move that this be referred to the Reference Committee on Constitution and By-Laws.

PRESIDENT ALEXANDER: I will so order.

This last is a change in the Constitution and cannot be made effective during this session of the convention.

The first amendment offered by Dr. Schaaf is referred to the Constitution and By-Laws Committee, and final action on the change in the Constitution and By-Laws may take place at our subsequent meeting Thursday afternoon.

DR. SCHAAF: There is a third proposed change in the By-Laws, which has been submitted by Dr. Decker. The present rule concerning the Post-Graduate Education Committee is this—

"The Committee on Post-Graduate Education shall consist of five members. It shall be the duty of this committee to provide a continuous program of post-graduate education for the members within the resources of the Society. It shall advise upon, correlate and promote all of the post-graduate activities of the special committees in cooperation with educational institutions."

The proposed change is to make the membership of the committee rotating; in other words, they will first be elected for one, two, three, four and five years, and after that, each will serve a five-year term. We ask that that be put into proper form and referred to the Reference Committee.

PRESIDENT ALEXANDER: This proposed change will be referred to the Reference Committee on Constitution and By-Laws.

DR. CHESTER I. ULMER: For some time it has been apparent that changes should be made in two offices of our State Society. First is that of Secretary. The time has arrived in the progress and perspective of our State Society for the Secretary to be a full-time official. He should occupy an office in our building in Trenton. He should be available to the profession and the public at all times; indeed, a physician-official should have an office in our building, rather than simply a bevy of girls, efficient and essential though they may be.

The following two qualifications are, I think, essential in the determination of applicants for Secretary:

1. He should, of course, be a physician, preferably one from our own state.

2. Besides being an able executive, he should have the qualifications of a public relations expert. He should with ability and dignity be able to represent the profession to the allied professions, to legislators, to educators, and to the public. He should ever be an alert liaison between the profession and the people. He

should be a comparatively young man, not over fifty years of age.

These remarks concerning a new secretary should not be interpreted as a personal attack upon the present incumbent, Dr. Stahl, but rather as a constructive plan to improve the prestige of The Medical Society of New Jersey. The remarks that I have just made are not a surprise to Dr. Stahl. Previous to this meeting I informed him of my intention and the text.

Recommendation No. 2 concerns the Executive Officer. It has now been almost four years since the death of Dr. LeRoy A. Wilkes. He was a capable and popular Executive Officer. Since his death, the work in the central office has been carried on largely by Mrs. Edith L. Madden. She has done the work most efficiently. She has tact, ability, and charm. With each change of administration yearly, we have learned to depend upon her ability, her experience and judgment. Mrs. Madden is indeed a valuable person.

I would propose, Mr. President and Members of the House of Delegates, that Mrs. Madden be made Office Manager, with a substantial increase in salary, and the office of Executive Officer be discontinued. I request that my remarks be submitted to the proper Reference Committee for their action and disposition.

PRESIDENT ALEXANDER: I will refer the remarks of Dr. Ulmer to the Reference Committee on Miscellaneous Business.

Reference Committees will meet this evening at eight o'clock in this room, and I hope all who have interest in the subjects brought up today will appear at these Reference Committees' meetings and press their viewpoints.

Dr. Stegen, representing the National Physicians Committee, will appear on our program this afternoon for a short talk. I have been asked to make this announcement by Dr. Londrigan, the President of the New Jersey Committee of the National Physicians Committee.

Upon motion regularly made and seconded, it was voted that the House recess until twelve-thirty the following day. Thereupon the House recessed at twelve-fifteen o'clock.

Wednesday Afternoon Session—May 22, 1946

The Second Session of the House of Delegates convened at 12:45 o'clock, President Alexander presiding.

PRESIDENT ALEXANDER: This meeting will come to order. The function of this meeting is to receive nominations of candidates for the various offices and to ballot for their elections.

May we have the Report of the Nominating Committee? Mr. Secretary of the Committee, may I have your report?

DR J. LAWRENCE EVANS: The following is a report of the Nominating Committee to the House:

President-Elect (1 year):
Royal A. Schaaf, Newark

First Vice-President (1 year):
J. Howard Hornberger, Roebling

Second Vice-President (1 year):
James F. Norton, Jersey City

Secretary (1 year):
Alfred Stahl, Newark

Treasurer (1 year):
George J. Young, Morristown

Trustees:

First District (3 years):
E. Zeh Hawkes, Newark

Fourth District (3 years):
William E. Dodd, Beach Haven

First District (3 years):
Elton W. Lance, Rahway

Councilors:

Third District (3 years):
Barclay S. Fuhrmann, Flemington

Delegates and Alternates to the A. M. A. (1947 and 1948 meetings):

Delegate (2 years):
Wells P. Eagleton, Newark

Alternate (2 years):
Elmer P. Weigel, Plainfield

Delegate (2 years):
Hilton S. Read, Ventnor

Alternate (2 years):
Lancelot Ely, Somerville

Delegate (2 years):
Thomas K. Lewis, Camden

Alternate (2 years):
Clarence W. Way, Sea Isle City

Delegate to fill unexpired term of Dr. McBride, deceased (1947):
William F. Costello, Dover

Delegates and Alternates to Other States (1947 meeting):
New York:
Delegate (1 year):
James F. Norton, Jersey City
Alternate (1 year):
D. Ward Scanlan, Atlantic City
Connecticut:
Delegate (1 year):
Alfred Stahl, Newark
Alternate (1 year):
C. Byron Blaisdell, Long Branch
Standing Committees:
Publication (3 years):
Lewis W. Brown, Newark
Scientific Work—Third District (5 years):
Patrick H. Corrigan, Trenton
Finance and Budget (6 years):
L. Samuel Sica, Trenton

PRESIDENT ALEXANDER: Thank you, Dr. Evans. Will someone move that the Report of the Nominating Committee be received?

DR. E. ZEH HAWKES: I so move.

The motion was regularly seconded, was put to a vote, and was carried.

For each office, additional nominations from the floor were called for and there were none. The candidates recommended by the Nominating Committee were therefore declared elected, the Secretary casting the ballot.

PRESIDENT ALEXANDER: All the nominees presented by the Nominating Committee have been duly elected. (Applause.)

We have with us today, representing the Medical Society of the State of New York, Dr. J. Stanley Kenney, Councilor, and Dr. Walter Palmer Anderton, Secretary. Will they stand, please? (Applause.)

Dr. Anderton, wouldn't you like to say a few words to us, just a few, to this group?

DR. W. P. ANDERTON: Mr. President and Ladies and Gentlemen: One of the greatest compliments I have ever had paid me by anyone in my life was paid by your President within the past few moments when he almost said I was from New Jersey. My great-grandfather used to live in Bayonne, and I have a lot of Jersey blood in me. It is a great pleasure to come to this very fine state of yours and to represent the Medical Society of the State of New York. We appreciate your asking us and feel highly complimented.

In these days it is of great importance for the medical profession from all parts of the country to stand and hang together. Our political opponents, particularly in Washington, are trying to ride roughshod over us and to harm the medical profession in a political way. The states and state assemblies through the A. M. A. can do much by hanging together.

We in New York are being very much benefited by your own contacts with the Veterans' Administration. We are a few months behind you in experience. We are just going to try to put in a plan after a little while. We have worked out a fee schedule, so that we are learning a great deal from the experience that you have had.

Allow me again not only in my own name but also in the name of Dr. Kenney and the Medical Society of the State of New York, to thank you all for your hospitality. (Applause.)

PRESIDENT ALEXANDER: Dr. Anderton, of course we would like to have you and Dr. Kenney stay with us and participate in the various programs that we still have to offer.

Are any of the doctors representing the State of Connecticut here? If not, the meeting stands adjourned.

(The House thereupon recessed at one-ten o'clock to reconvene on Thursday afternoon, May 23, 1946, at one-thirty o'clock.)

Thursday Afternoon Session—May 23, 1946

The Third Session convened at one fifty-five o'clock, President Alexander presiding.

PRESIDENT ALEXANDER: The Third Session of the House of Delegates will come to order. Is there any representative of the State of Connecticut here? Dr. Stringfield and Dr. Root, on behalf of the House of Delegates, we extend to you a cordial welcome. I am sure you will find that something constructive will come out of this session this afternoon. (Applause.)

Now we will go on with the reports of Reference Committees, and the first is the Report of Reference Committee A.

DR. FREDERIC W. LATHROP read the following report:

REPORT OF REFERENCE COMMITTEE A

Your reference committee received and approved the reports of the President, the Secretary and the Councillors. The report of Trustees concerning the selection of one or more medical coordinators detailed to the Office of

Veterans Administration * and recommending a special assessment for this purpose has been carefully studied. This is a vital matter which is just now in a state of evolution. The present practice of handling medical care for veterans through the Medical Service Administration has proved unworkable.

The Medical Service Administration wishes to stress the fact that there has been no breakdown in cordial and cooperative relationship with the Veterans Administration; and, that the abrogation of the present contract was purely a technicality accompanied by a gentlemen's agreement that it be replaced immediately by a new arrangement.

It now seems the most practical solution to have a physician employed by the State Society placed in the Office of the Veterans Administration to act as liaison officer and thereby protect the interests of the medical profession. It is hoped by the committee that the new Executive Officer can fill this position for the time being. The liaison officer will act through a liaison committee for the State Society and similar committees in each county society to adjust any differences that may arise between the veteran patients, the Veterans Administration and the practicing physician. We realize that necessary funds will be required. This aspect will be presented by Reference Committee B.

Your Reference Committee offers the following resolutions:

1. That The Medical Society of New Jersey finance the cost of an officer to act as Coordinating Officer with the Veterans Administration.

2. If it is legally possible and advisable, The Medical Society of New Jersey deal directly with Veterans Administration through a State Liaison Committee and paralleling county committees.

Dr. Barkhorn: I move that this report be received and approved.

Dr. Herrman: I second that.

Dr. Sprague: It is to be remembered that we have recommended a coordinating officer to facilitate medical service to the veteran. The present report seems to stress the value of such a plan to the doctor; I should like to see incorporated in the report, the fact that this procedure would expedite medical care of the veteran.

Dr. Lathrop: I am sure the committee will accept that.

President Alexander: Any discussion? All in favor say "Aye"; contrary "No". The motion is carried.

Report of Reference Committee B

Dr. Daniel F. Remer: Reference Committee B considered the reports of the Treasurer, of the Finance and Budget Committee and of the Publication Committee. The report of the Treasurer was in full form as of May 15, 1946. The committee congratulates Dr. Young on his splendid report, has approved that report, and I now move its adoption.

Dr. Alter: Seconded.

President Alexander: Is there any discussion? If not, all in favor say "aye"; contrary, "no". It is adopted.

Dr. Remer: The report of the Finance and Budget Committee was next heard. After careful examination and discussion the budget for 1946-1947, total $71,850.00, was adopted.

Also the following recommendations of the Finance and Budget Committee were adopted:

1. That the policy of the State Society to give a dues credit to members in service be continued for 1947 dues.
2. That members separated from service after October 1, 1946, be given a dues credit for 1947.

The third recommendation of the Finance and Budget Committee was that the per capita assessment for 1947 be $20.00. In view of the recommendation of Reference Committee A—"that The Medical Society of New Jersey finance the cost of an officer to act as Coordinating Officer with the Veterans Administration"—your Reference Committee recommends that the per capita assessment for 1947 be $25.00.

The committee has done a splendid job on this report and I, therefore, move adoption of this report.

Dr. Harrold A. Murray: Seconded.

President Alexander: Is there any discussion? If not, all in favor say "aye"; contrary-minded, "no". It is carried.

Dr. Remer: The report of the Publication Committee was presented by Dr. Barkhorn. This committee deserves a great deal of credit for its achievements this year. The standard of our Journal is high, and it has been operated at a profit of $6,000 to the Society. The committee hopes, with the return of Dr. Davidson and many other veterans, to improve the editorials and scientific articles in the coming year. The Reference Committee approves the report and I move you its adoption.

Dr. Alter: Seconded.

President Alexander: Is there any discussion? If not, all in favor say "aye"; contrary-minded, "no". The motion is carried.

* Printed on page 283 of the July, 1946, Journal.

DR. REMER: I move the report of the committee as a whole be adopted.

DR. BARKHORN: Seconded.

(The motion was put to a vote and was carried.)

REPORT OF REFERENCE COMMITTEE C

DR. SIGURD W. JOHNSEN: Reference Committee C recommends approval of the reports submitted by the Medical Service Administration covering the Farm Security Plan and the City of Newark Plan. The latter has proved successful in providing medical care for the indigent and medically indigent in a community which assumes responsibility for the care of its indigents.

Part III of the report pertaining to the Veteran's Plan for service-connected disabilities is now being considered by the Trustees and, therefore, no action was taken by this committee on that matter.

Reference Committee C recommends the approval of the report submitted by the Medical-Surgical Plan of New Jersey.

There has been a slow but healthy growth of this organization and the committee would recommend that every member of our State Society give this organization his whole-hearted support.

Reference Committee C recommends the approval of the report submitted by the State Board of Medical Examiners of New Jersey.

DR. JOHNSEN: I move the adoption of the report.

PRESIDENT ALEXANDER: You are adopting the whole report now. Is there any discussion?

DR. JAMES F. NORTON: I second the motion for adoption.

(The motion was put to a vote and was carried.)

REPORT OF REFERENCE COMMITTEE D

DR. DAVID B. ALLMAN: The duties of this committee were to discuss the reports of the following committees: Post-Graduate Education, Scientific Work, Medical Defense and Insurance, Delegates to the A. M. A. and the Advisory Committee to the Woman's Auxiliary.

We have studied the report of the Committee on Scientific Work and recommend its approval. I so move, Mr. Chairman.

DR. MURRAY: Seconded.

(Motion was carried.)

DR. ALLMAN: Reference Committee D approves the report of the Committee on Medical Defense and Insurance, and commends Dr. Beling and his committee members for their fine work. We emphasize especially their recommendations which are as follows:

(A) *Medical Defense Insurance:* (a) Renewal of the special policy of the U. S. Fidelity and Guaranty Company. (b) Congratulations to the company on its fiftieth anniversary. (c) The continuation of Messrs. Faulhaber & Heard as our official brokers.

(B) *Accident and Health Insurance:* The continuation of Messrs. E. & W. Blanksteen as our accident and health insurance representatives during the coming year.

DR. ALLMAN: I move the adoption of this section of the report.

DR. THOMAS K. LEWIS: Seconded.

(The motion was put to a vote and was carried.)

DR. ALLMAN: The committee highly recommends approval of the report of the Advisory Committee to the Woman's Auxiliary and commends Dr. Dodd and his committee members for the fine work they have done and wishes to place on record our appreciation of the interest of the Woman's Auxiliary on behalf of organized medicine. I move adoption of this portion of the report.

DR. ALTER: Seconded, and I want to say that the ladies do more than the men. Doctors are busy people. There is a great contrast in the present day from the situation when my uncle was practicing, when the priests and ministers used to go to the doctors to consult with them about the work of the parish. Today the medical man has little time for personal contact with community affairs, and our contact is provided through the women of the Auxiliary. They are indispensable to us in keeping that contact. It is a very serious matter, and we are grateful to them. We should utilize the Auxiliary to a greater extent in this way.

PRESIDENT ALEXANDER: Is there further discussion?

(The motion was put to a vote and was carried.)

DR. ALLMAN: Your reference committee recommended approval of the report of the delegates to the American Medical Association.

DR. LONDRIGAN: Seconded.

(Put to a vote, the motion was carried.)

DR. ALLMAN: Your reference committee reviewed with interest the new proposal for post-graduate education and wishes to recommend approval of that report on an experimental basis. We feel that their efforts are steps in the right direction, the efficacy of which can be evaluated only by trial and error. We recommend the approval of this report.

Dr. Londrigan: Second the motion.

(Put to a vote, the motion was carried.)

Dr. Allman: I now move adoption of the report in its entirety.

Dr. Lewis: Seconded.

(Put to a vote, this motion was carried.)

Reference Committee E

Dr. Barkhorn: We have carefully reviewed the records of the meetings of the Welfare Committee and Subcommittees and Advisory Committees as published in The Journal, as well as the annual reports and the supplementary reports. We congratulate the committees on their progressive work and on their alertness in bringing so many activities to the attention of the members of The Medical Society of New Jersey.

Dr. Sica, for the Public Relations Subcommittee, recommends the establishment of a bureau of doctors to speak on economic topics at a county level. We concur in this recommendation and urge its adoption.

Dr. E. Zeh Hawkes: Seconded.

(Put to a vote, this motion was carried.)

Dr. Barkhorn: Dr. Nichols for the Public Health Subcommittee presents a splendid report with two recommendations. First: That a full-time executive secretary be provided the Chairman of the Public Health Committee and the chairmen of the fourteen advisory committees. We do not concur in this additional expense, since the central office, as now constituted, is capable of carrying on all clerical work and because we feel that many of the advisory committees could be combined with one man from the Public Health Committee assigned to cover the activity and to report to the main committee; this consolidation would foster better administrative work. We do, however, urge the early employment of an Executive Secretary for The Medical Society of New Jersey. Dr. Nichols' second recommendation was that the county societies reconstitute their Public Health Committees on the model of the state committee. We concur in this if it does not mean too great a division in activities. I move the adoption of this part of the report, except for the clause recommending a full-time secretary for the Public Health Committee and its subcommittees alone.

Dr. Sprague: Seconded.

(Put to a vote, this motion was carried.)

Dr. Barkhorn: The Mental Hygiene Advisory Committee recommends that in cooperation with a corresponding committee of the State Department of Institutions and Agencies, mental hygiene and psychiatric facilities be expanded at all levels. We concur and move the adoption of this part of the report.

Dr. Lewis: Seconded.

(Put to a vote, this motion was carried.)

Dr. Barkhorn: The Subcommittee on Legislation has submitted, as usual, an exceptionally comprehensive, enlightening and instructive report. In it they again draw attention to the Wagner-Murray-Dingell bill and the Pepper bill. They pay especial attention, however, to Senate 2143. This provides for a National Health Agency in the executive branch of the government administered by a National Health Administrator — a doctor of medicine — appointed by the President and confirmed by the Senate. The health needs would be determined at the local level, without compulsion, and the state's contribution would be two-thirds, the federal contribution being one-third. This safeguards against indiscriminate projects. We urge that this House of Delegates go on record as approving such principles and that the Subcommittee on Legislation be instructed to write to our representatives and other interested parties informing them of our reiterated and continued opposition to the Wagner-Murray-Dingell bill and to the Pepper bill; and, in contrast, our support of the principles of S. 2143.

Dr. Barkhorn: I move the adoption of this part of the report.

Dr. James F. Norton: Mr. President and Members of the House of Delegates: I don't think there is anyone here who will question my devotion to the cause of organized medicine in this state and in this country. We have moved a bit precipitously in other matters affecting the practice of medicine and organized medicine, and for us now to present a blanket endorsement of the principles embodied in the Taft bill, I think, again, is acting a bit precipitously.

I am unalterably, unquestionably, uncompromisingly opposed to the Wagner-Murray-Dingell bill and everything that it implies. I only caution you against now putting our State Society on record in favor of a proposed piece of legislation which has not had, so far as I know, any official opinion from our great parent organization, the American Medical Association, and which piece of legislation I am positively certain not 2 per cent of the members of this House of Delegates are familiar with.

I am heartily in favor of the report of the Reference Committee as presented. I should like definitely to delete from it any reference commendatory of the Taft bill until or unless we get an official pronouncement from an

authoritative source speaking for organized medicine in this country. We might well find ourselves in opposition to the position taken by the A. M. A. if we do this now.

There is no hurry. Why do that? There is time. We should have opportunity—we should proceed slowly. I ask for the deletion of that part of the report referring to the Taft bill, and I so move.

DR. LONDRIGAN: Seconded.

PRESIDENT ALEXANDER: Is there further discussion?

DR. BARKHORN: The actual principles that we are advocating are that there shall be a National Health Administrator, a doctor of medicine, appointed by the President, confirmed by the Senate, which means essentially a Cabinet member, for which we have been on record for many years; that we approve of the fact that there is no compulsion in this bill; that we approve of the fact that two-thirds of the funds must come from the state, as compared to many others in which, in the northern states 90 per cent comes from the state and 10 per cent from the federal government, and in the southern states 10 per cent comes from the states and 90 per cent from the U. S. government.

The bill, as a whole, was, of course, summarized and passed around. I realize that people have had but little or no opportunity to study it; on the other hand, I feel that when governmental officials such as Senator Smith, who is sincerely, apparently, on our side, and Senator Taft, who certainly publicly came to our rescue, made an effort that seems to fulfill our needs very closely, the time has come when instead of resting on our oars waiting for a slow-acting American Medical Association to come to the fore, we should go on record and inform them of our position instead of waiting for them to inform us. (Applause.)

DR. NORTON: I am not in controversy with the principles enunciated in the Taft bill. It may well be the time may come when I will be more vocal in espousing its principles than even Dr. Barkhorn.

On July 1 of this year the American Medical Association meets in San Francisco. Only the other day I had occasion to talk about this. The idea of the Taft bill did not just occur to me as I was sitting here. The other day I had occasion to talk to an individual who is very active in the affairs of national medicine and who has done more foot work in opposition to the Wagner-Murray-Dingell bill than the whole State of New Jersey, perhaps, put together—and I mean foot work, now. He discussed the Taft bill. I will go along, and I will be perfectly willing to go along with an enunciation of principles, but I think we should delete the reference to it specifically as "the Taft bill". We are not going to get mixed up in a political controversy between Taft on one side and Murray on the other, and New Deal on one side and anti-New Deal on the other. That is not our problem.

Our problem is medicine and what is best for medicine, and if it is best for medicine, that we identify this as it is.

DR. WILLIAM G. HERRMAN: Could we not recommend that our Delegates to the A. M. A. Convention inform the A. M. A. in convention that The Medical Society of New Jersey approves the principles of the distribution of medical care as set forth in the present Senate bill—whatever the number may be? We do not know how that bill might be amended; we therefore do not want to recommend this bill by number, while quietly we certainly are as a group in full approval with the principles as enunciated in it.

I rather agree, with the A. M. A. meeting so soon, that the passing of our approval on to the American Medical Association is quite the organization way to do it, and it would still give notice to the public of the general principles of which we approve.

DR. FREDERIC J. QUIGLEY: Mr. President, I think perhaps as the Executive Secretary of the Legislative Committee, and the person to whom you look for most of the spade work on bills for your information, so that you can decide intelligently what should be your course of action here, I should like to say a few words.

In the first place, this bill, at the very beginning, does something which organized medicine throughout the country for over sixty years has been advocating; namely, that all the health activities of the Federal Government be consolidated into one department. Now, that is the first thing that this bill proposes, to establish a Federal Health Agency, and all these several departments, including the Public Health Service and the Children's Bureau, would be consolidated into that one agency.

The Director of the Budget is also instructed to make a survey of the other health activities in other departments of the Government and to report by June, 1947, as to what other health activities of the Federal Government can be properly amalgamated into this new department; so on that point, there can be no question that organized medicine, the A. M. A. and every state organization have advocated that; and that, incidentally, it seems to me, is the

first step that must be taken in any proposition that has to do with the setting up of health care of the nation, first to get all the agencies that have to do with health, into one department.

I think there is much to be said about Dr. Norton's admonition not to go too precipitiously about this. Still, if this bill does enunciate principles which we are trying to approach, and is in accord with our thought as to how this should be done, we should endorse it. I am inclined to think that perhaps with an expression of such sentiment to the Board of Trustees, awaiting a pronouncement from the American Medical Association, we would take the type of action that Dr. Norton has suggested, and which is in accord with the remarks of Dr. Herrman.

Dr. Sprague: I think we should inform Senator Smith that we approve and appreciate the position he has taken, that he seems to have an understanding of the principles for which we stand.

Dr. Barkhorn: I move the adoption of this resolution with the substitutions made by Dr. Herrman and Dr. Sprague; in other words, that we instruct our Delegates to the A. M. A. that we are in favor of this principle, and that we notify Mr. Smith that we are interested in his cooperation and appreciate his knowledge of the subject.

Dr. Norton: I will second that.

Dr. Ralph K. Hollinshed: I feel that Dr. Norton is justified in his stand. The Taft bill embodies many of the things for which we have been fighting but it is not perfect. It would be much better if the House of Delegates feel that they want to do something about it, to make it known to the Board of Trustees of the State Society that they are in favor of the principles embodied in the Taft bill, and suggest to the Board of Trustees that the Delegates be empowered to get across to the proper committees in the A. M. A. the feeling that if they have nothing better to offer, The Medical Society of New Jersey endorses the Taft bill in principle.

I think it would be a mistake for us to take definite action on the Taft bill, just as Dr. Norton has said, before any action was taken upon it by the A. M. A.

Dr. Thomas K. Lewis: All of the principles, Mr. President, brought forth in this report have already been approved by the House of Delegates of the American Medical Association. There is no question about that. Support of an actual bill is the only question; the only sensible thing to do is to reiterate our support of those principles and empower the Board of Trustees of this Society to support actively this bill if and when the American Medical Association has taken the same action. (Applause.)

President Alexander: Before we vote on it, I think we ought to have the motion read.

Dr. Barkhorn: We are discussing the Report of the Reference Committee E on the report of the Legislative Subcommittee. They pay special attention to the Taft-Smith-Ball bill.

"This bill provides for a National Health Agency in the executive branch of the Government, administered by a National Health Administrator—a doctor of medicine—appointed by the President and confirmed by the Senate. The health needs to be determined at a local level without compulsion, the state contributions to be two-thirds and the national one-third, thus preventing indiscriminate projects. We urge that this House of Delegates go on record as approving of this bill in principle and that the Subcommittee on Legislation be instructed to write to our representatives and other interested parties, informing them of our reiterated and continued opposition to the Wagner bill and the Pepper bill, and, in contrast, of our support of the Taft-Smith-Ball bill (S. 2143) in principle."

And, instead of that last we could say, "our support in principle" of these facts which I have just enumerated. Any of the solutions offered here all come back to the same point. I have been making an effort to assume leadership instead of following up, but they all come back to the same point, and it is the principles of the Taft bill we approve, but we don't have to mention the Taft bill; we can mention the principles of which we approve, and that is satisfactory if you want to vote on the principles and delete the other statement.

Dr. Norton: I will second that motion, or the motion of Dr. Barkhorn that the report of the committee as now enunciated by Dr. Barkhorn be adopted, with the deletion of the words "the Taft bill," and inclusion of support of the principles of the bill.

President Alexander: Is there any further discussion? All in favor say "aye"; contrary-minded, "no." It is carried.

Dr. Barkhorn: We now move adoption of the report on the reports of the Welfare Committee, the Subcommittees to the Welfare Committee, and the Advisory Committees to the Subcommittees of the Welfare Committee, as a whole, with the exceptions noted. I move its adoption.

Dr. Alter: Seconded.

(The motion was put to a vote and was carried.)

President Alexander: We will now hear from Dr. Schaaf, as chairman of the Reference Committee on Constitution and By-Laws.

COMMITTEE ON CONSTITUTION AND BY-LAWS

DR. SCHAAF: First, the committee considered the proposed change in Section 5 of Article IV of the Constitution, a change which permits persons other than physicians to be elected to Honorary Membership. As so amended, the section would read as follows:

"Honorary members shall be physicians and surgeons who have attained distinction within the medical profession, **or non-medical persons who have rendered signal service to The Medical Society of New Jersey or who have attained special eminence in scientific fields other than medicine,** and who may be elected by a two-thirds vote of the House of Delegates after having been recommended by the Committee on Honorary Membership; provided the number of living Honorary Members does not exceed fifteen (15). They shall have all the privileges of members, but shall not be members of the corporate body." *

I recommend the approval of this change and its processing through the usual course provided in Article XII of our Constitution. I so move.

DR. MURRAY: Seconded.

DR. SCHAAF: This change in the Constitution requires two readings and it cannot be adopted at a single session of the House of Delegates. It requires also publication to all County Societies and publication in the JOURNAL before being read at the next Annual Meeting; so no further action on this proposal is necessary today except to approve the recommendation that it take the usual course that is required in Article XII.

DR. LONDRIGAN: Seconded.

PRESIDENT ALEXANDER: Any discussion? All in favor signify by saying "aye"; contrary-minded, "no." It is carried.

DR. SCHAAF: The Reference Committee recommends the adoption of the following amendment:

"The Committee on Post-Graduate Education shall consist of five members. **The first appointment shall be for a period of one (1) year; the second appointment shall be for a period of two (2) years; the third appointment shall be for a period of three (3) years; the fourth appointment shall be for a period of four (4) years; the fifth appointment shall be for a period of five (5) years; and as the terms of these members expire, new appointments shall be for periods of five years.** It shall be the duty of this committee to provide a continuous program of post-graduate education for the members within the resources of the Society. It shall advise upon, correlate and promote all of the post-graduate activities of the special committees in cooperation with educational institutions." *

This requires only a second reading at this session of the House and therefore, Mr. President, I now move the adoption of this amendment to our By-Laws.

DR. ALTER: Seconded.

PRESIDENT ALEXANDER: Bear in mind when you vote for this proposal, you adopt it as part of your By-Laws. Any discussion? If not, all in favor say "aye"; contrary-minded, "no." It is carried.

DR. SCHAAF: The Reference Committee recommends the adoption of the following amendment to Section 2d of Chapter 1 of the By-Laws:

"The Official List as published each year shall be prima facie evidence of the right of members to register at the annual meeting, and, unless otherwise ordered by the House of Delegates, shall form the basis of representation of each component society, **except that after the Official List is printed, any component society which finds that it is entitled to additional delegates and alternates may elect these at its April or May meeting."** *

DR. SCHAAF: I move, sir, that this amendment to the By-Laws be adopted.

DR. NORTON: Seconded.

(The motion was put to a vote and was carried.)

DR. SCHAAF: I now move that the report as a whole be adopted.

DR. ULMER: Seconded.

(The motion was put to a vote and was carried.)

MISCELLANEOUS BUSINESS COMMITTEE

DR. DAVID W. GREEN read the following report:

1. *Annual Meeting Committee.* This Reference Committee feels that an excellent program has been prepared and we accept the report of the Annual Meeting Committee and commend them for the excellent and instructive program.

2. *Scientific Program Committee.* We accept the report of the Scientific Program Committee and commend them for the fine program which they have presented under existing conditions.

3. *Place and Date of 1947 Annual Meeting.* We suggest the Hotel Haddon Hall in Atlantic City, if available, at a date previous to the meeting of the American Medical Association; the exact date to be determined by the Board of Trustees.

4. *Intern Training Committee.* This Reference Committee considered the letter from Dr. Schlichter and approved its contents.

5. *Dr. Ulmer's Resolution consolidating the positions of Secretary and Executive Officer.* (See page 8, these TRANSACTIONS. This committee does not approve of the resolution consolidating the office of Secretary with that

* Words in bold-face represent additions to the section proposed in this recommendation.

of Executive Officer; but the committee does recommend the appointment of an Executive Officer at the earliest possible moment with the qualifications suggested by Dr. Ulmer.

(Each section of the above report was separately presented and on separate motion each was approved and adopted.)

DR. GREEN: I now move adoption of this report as a whole.

(This motion was seconded and carried.)

RESOLUTIONS AND MEMORIALS

DR. LEO D. HAGGERTY: Dr. Newcomb appeared before our committee and cited numerous cases of advanced tuberculosis among migrants.

It was moved by Dr. Armstrong that the following resolution be approved:

"Resolved, That the matter of tuberculosis control of migrant labor in this state be referred to the Advisory Committee on Tuberculosis and to the Sub-Committee on Legislation for appropriate action."

Seconded by Dr. Bowers and approved unanimously.

DR. HAGGERTY: We recommend the adoption of this report and I so move.

DR. ALTER: Seconded.

(The motion was put to a vote and was carried.)

CREDENTIALS COMMITTEE

PRESIDENT ALEXANDER: Reference Committee on Credentials will now be heard from.

DR. THOMAS B. LEE: There is no report. The attendance was 1347, which we think is very satisfactory. There were a few questions of eligibility and I think they were taken care of satisfactorily. The attendance score is as follows:

Physicians	781
Others	566
Total	1347

(Upon motion regularly made and seconded, it was voted to accept the report of the Reference Committee on Credentials.)

PRESIDENT ALEXANDER: Now we will go to Unfinished Business. Dr. Harvey, President of the Essex County Medical Society!

REMISSION OF DUES

DR. THOMAS W. HARVEY, JR.: This is a request for suspension of the rules in order to introduce a resolution to benefit certain veterans who are not apparently at present receiving remission of their dues.

PRESIDENT ALEXANDER: Is there any objection to the request to suspend the rules? I hear none. Dr. Harvey, you have the consent of the House.

DR. HARVEY: I wish to present this resolution:

> Whereas, The Medical Society of New Jersey has remitted the dues of all honorably discharged veterans in good standing for the year 1945 and the ensuing year; and
>
> Whereas, Many veterans were called to active service with the armed forces of the United States before this date; and
>
> Whereas, Many veterans had been called before payment of their dues for the year when they were ordered on active duty and therefore are not in good standing in the State Society; and
>
> Whereas, Some veterans have been honorably discharged from service before 1945 and were in good standing in the State Society; be it
>
> *Resolved*, That the Council of the Essex County Medical Society hereby recommends to the State Society that all honorably discharged veteran physicians in good standing or not, be granted remittance of dues for one year by the State Society upon establishing or reestablishing their membership in their respective County Societies within ninety days of their discharge from the armed forces of the United States.

There were several men who apparently had let their dues slip in 1941 and 1942 and went into the service a few months after the year started, and hence were dropped by the Society, and they feel that they should be granted a remittance of dues as the other men are.

DR. ALTER: Isn't that a question for each of the county societies?

DR. HARVEY: No, it is a question of the State Society collecting the larger portion of the dues from the County Society.

I move the adoption of this resolution.

DR. NORTON: Seconded.

PRESIDENT ALEXANDER: Is the resolution clear to everyone?

DR. COSTELLO: Isn't it the per capita tax against the county that we remit?

PRESIDENT ALEXANDER: Yes.

DR. REEVE L. BALLINGER: I just want to ask for information, if I understood the gentleman, how can we remit dues of a man who is not in good standing? Why was he not in good standing? Did I misunderstand?

PRESIDENT ALEXANDER: He hasn't paid his dues.

DR. BALLINGER: How can we remit his dues if he hasn't paid them?

DR. SCHAAF: Supposing that on the 15th of March, 1942, the Official List closed for the year 1942, and on March 20th a man was ordered into military service. He lapsed his dues five days and didn't come back for two years. He was dropped because he didn't pay his dues on March 15, 1942, whereas he actually was in military service. There are only a few men

affected and they feel that an injustice is done to them if they aren't given a remission of dues for one year, or a portion of another year, which prevails for all other medical officers.

PRESIDENT ALEXANDER: There is one thing, Dr. Schaaf—it isn't clear. Will you make clear—it isn't clear in my mind—you say these men went in on the 20th of March. Did they pay any dues after that?

DR. SCHAAF: No. They went in but were not in good standing inasmuch as their dues were not paid as of March 15; however, if they were not in the service, they might have been delinquent a month or two months, but would have then paid. Their failure to remain in good standing was due to entrance into the military service. They feel that all men who got out in 1944 and '45 have had a year's remission of dues and in some instances more than that. Those men who failed to be in good standing, through no fault of their own, think they should get one remission of dues like any other medical officer.

Essex County has adopted that as a resolution so far as their Society is concerned, contingent on a similar arrangement with the State Society.

PRESIDENT ALEXANDER: You mean last year's dues. They paid before they went in the service.

DR. SCHAAF: One year's dues, regardless.

DR. HARVEY: Also, the men discharged in 1942 went back in the Society.

DR. SCHAAF: Couldn't be made retroactive —I don't know when the dues were suspended but men in the service and discharged before that date did not get a year's remission of dues, and they feel they should have it.

DR. ALTER: Good standing of a member starts in the county society. It is up to Essex County to decide for itself. Obviously it is the privilege of other county societies to settle it for themselves, and then when it comes to the jurisdiction of the State Society, I think it is not a matter for the State Society to decide.

DR. RUSSELL K. TETHER: One was for a man not in good standing and the other for a man in good standing. I don't see why you should consider the two things in one.

DR. MORRIS JOSEPH: I think the entire matter ought to be thoroughly studied, and a ruling laid down by the proper committee and distributed among all county societies. We can go into a lot of discussion here and confusion, and I believe it does require study. I think every veteran should be given proper consideration, and I think he won't be given the proper consideration unless and until we study all the different phases of this, and after there is study by a proper committee, we can have a ruling which would be uniform, which should be distributed to all county societies.

DR. COSTELLO: I move it be referred to the Board of Trustees.

DR. JOSEPH: Seconded.

PRESIDENT ALEXANDER: Any discussion? All in favor say "aye"; contrary-minded, "no." It is carried.

Is there anything else under Unfinished Business?

Under New Business are there any matters to be brought up? If not, at this time it is my pleasant duty to present to you the next President of The Medical Society of New Jersey. I am sure Dr. Scammell can count on the cooperation of every member of the State Society to the end that he may have a very succesful administration. Dr. Scammell, let me present you as the new President of the State Society.

(The members rose and applauded.)

THE NEW PRESIDENT

PRESIDENT SCAMMELL: As I sat there I was filled with what I thought I should talk about, but to receive the approbation to be your President for the following year, even with my rugged personality, being able to withstand some conversations, rather warms my heart and warps my vocabulary.

I have been selected by the members of this state, and when I say that I appreciate it very, very much, it is only putting it very, very mildly.

I felt that it might be interesting for you to know somewhat of the conditions under which I gleaned my education, and, in a way, so to speak, I am going to try to prove my stewardship for The Medical Society of New Jersey.

I should like to conform to the slogan that one of my predecessors gave me when I was made the County Physician in Mercer. I went up to his house and I said to him—it was Dr. Richard R. Rogers—"Dick, I have had the caucus nomination for the County Physician, and I have come up to see you with reference to getting some instruction."

"Well," he said, "Scammell, if my predecessor had given me the instruction that I am going to give you, it would have saved me a tremendous amount of trouble; so my instruction to you is this: As long as you are County Physician, don't make yourself any trouble."

I have tried to follow that in my work and have been partly successful, and I think now—you are probably listening to the last of the Presidents of this Society who arrived at his professional goal through an apprenticeship in a drugstore, a student in a doctor's office, and a student of my preceptor, having a preceptor

prior to going to college, and working at odd hours in the drugstore, and in the vacations in a doctor's office.

My high school education was interrupted in its third year by an attack of pneumonia in the spring, and my parents made an arrangement for employment in a small abattoir, so that I could have the advantage of fresh blood almost daily. I was fortunate to gather strength rapidly enough so that I became a paid employee and was detailed to take care of the sheep and calves, also to knock the beeves in the head, dress the intestines, and wash the stomachs of the ones intended for tripe.

It might be interesting for you to know how I perfected my education to pass the examination into medical school. The night school at the high school was conducted by the teachers I was fortunate enough to have when I was a day pupil and they gave me the subjects necessary for my entrance, with the exception of physics. The question of physics was solved by my getting a copy of John Marshall's notes (printed) from a former first-year student at the University of Pennsylvania, from which I understood, Professor Wormley, professor of chemistry, asked questions on entrance. I memorized 32 pages (our house 32) and I can still see the slight smile on the doctor's face when I answered his questions.

My training with my preceptor—one year (Dr. Rice)—before going to college (and I might say he had the reputation of being one of the best therapeutists in Trenton) gave me the opportunity to ascertain the therapeutic effects of the many drugs.

After entering college, my first vacation was spent as a drug clerk in Dr. Coleman's Drug Store in Asbury Park (incident to working there) for the reaason that I understood that they paid higher wages at the shore. After getting off at the station in Asbury Park, I crossed the street to a drugstore conducted, I think, by Hernell and Schenck, and I went in and interviewed one of the proprietors and asked if he had any use for a person of my age and knowledge during the summer months. He said they did, and offered ten dollars a week. "That won't pay my board down here, will it?" I asked. "Oh yes," he said, "you will be a full-season person and I can get you an excellent boarding house for five dollars a week."

Then I asked, "You expect me to wait on the trade over the counter and if there is any unusual rush at the soda counter will expect me to give some assistance there?"

He said, "That's it exactly."

"Do you buy my shoes?" I asked.

He said no.

"Do you buy my pants?"

"No."

"Well," I said, "you know that no one can be a clerk behind a soda counter without spoiling his shoes and spoiling the bottoms of his pants. I come from a family in which it is necessary for me to have all the monetary consideration that I can take back home with me so as to have a bearing on the expense of my college career and I don't think that I could stand it here."

Looking around, I said, "I see you have a cash register."

"Oh, yes, we have a cash register."

"Well," I said, "I couldn't work here with you having a cash register."

He said, "What do you mean to imply? Do you mean to say my clerks are not all right?"

I said, "I don't imply anything but from the fact that you pay them the same amount of money that you might pay me in proportion to services, they know something about the drug business that you haven't interpreted as yet."

So he wanted to know if I had a reference and I said, "Yes, I do."

He said he would like to see it, and I said that I didn't think that any boy that got ten dollars a week needed any references, and I wouldn't show it to him.

"Well," he said, "what are you going to do?"

I said, "I am going further, and I am going to see if I can't get a job with somebody else."

He said, "If you don't get one, you come back here."

I said, "I won't be back."

So after that controversy with him, I went to see Dr. Kinman in Asbury Park, and he said they kept their clerks all year, and he had a place for me, but only during the month of August.

I said, "That won't do."

So I went further until I met Dr. Coleman, on the corner of Cookman Ave. and Kingman St., and he asked me where I was from, and I told him, and he wanted to know if I knew his cousin, and I said that I did. I knew him very well.

He said, "Whom did you work with?"

When I told him, he said, "Well, he is the orneriest druggist in the State of New Jersey."

I said, "No."

"Well, the drug salesmen tell me so."

"Well," I said, "he may not be very much ingratiated in the minds of the drug salesmen, but he is a fine man and he never asked me to do anything he wouldn't do himself."

The fact of the matter is, he never asked me to wait on anybody in the trade after I returned from supper, but just noted a few of the drugs which were commonly used, and he used to say to me, "Now you park yourself in the corner and study those up, and I will give you a quiz on them before you leave at quarter of nine."

Dr. Coleman asked me if I had a reference and I told him I did and he said, "May I see it?"

I said, "Yes," and I showed it to him, and he held up his hands and said:

"How much do you ask for a recommendation like that?"

I said, "Fifteen dollars for June and twenty dollars for July and August."

He said, "You will get a telegram from me to be here the first day of June."

I said, "I will be here."

After my first year in college, that was, I think, and I went to the shore and worked again.

My other vacations until I was graduated were with my brother-in-law, Dr. Mitchell

Reese of Phillipsburg. He was a very good quiz master, an excellent internist and a good minor surgeon.

To light up the difference between interns now and the completion of the service then, I want to tell you this: during my second year, there was a man by the name of Heater. a laborer in the quarry back of Tom Newman's stable in Phillipsburg. While Heater was picking up stones, a good-sized stone went down, struck his forefinger and crushed it and split the bones in half, so when they brought him up to the doctor's office, I had him come out on the side porch, which was fairly well protected from anything on the main street, and had Lizzie (the clerk in the kitchen) sit down on a pillow and give Mr. Heater a little chloroform. I amputated his finger and fixed it up.

My second operation, during my second year, was a man by the name of George Nuttle, who was employed by Floyd Haggerty, the iceman, and, as you well know, during those times they would cut the ice along the rivers and pile it in these houses and cover it with sawdust to keep it until summer. They had iron bars about three feet long which had rather a flange on them, and with the end very sharp, so they could pry out and cut these cakes of ice. As Nuttle was stepping across, one of the men happened to be going to cut, and struck him and cut the tendons on top of his foot. The man who did this was a man by the name of Roberts—I might say, Dr. Roberts, who was a '98 man, and he was working his way through college by working for Mr. Haggerty. Dr. Roberts afterwards became the Mayor of Easton.

I pressed Lizzie into service and gave him a little chloroform and sutured his tendons, and not knowing when I would see him again, doing the best I could, because the doctor was making some calls over the country and couldn't get back in time.

About five years ago, in going around through the hospital making my rounds, I happened to go into the convalescent portion of the hospital, where the men were playing games, and I saw a chap sitting there, and looked at him, and I thought to myself, "You look like George Nuttle," and I said, "Isn't your name Nuttle?"

He said, "Yes, sir."
"How are you, all right?"
"Yes."
"What was the matter?"
"I'm better now. I had a bad cold."
I said, "Do you remember who I am?"
"No."
I said, "Get up a minute and let me see how you look. Just walk down the room there a little. I want to see how you walk."
He walked down there and I said, "You don't limp any more, Nuttle, do you?"
He said, "I haven't limped for a good while. Now I know who you are. You are Dr. Reese's brother-in-law."
I said, "Yes."
I felt pretty good over that.

My next innovation was in obstetrics, in my second year. One morning my brother-in-law called me about three o'clock and he said. "Now, Frank, you will have to go up to Marble Hill."

Marble Hill is at the reservoir for the Phillipsburg water supply.

So I said, "All right, I had better go down and get the horse."

"No. you will have plenty of time. You just walk up there."

That was about a three-mile walk up to the top of Marble Hill, and I had a primipara, fortunately not a difficult one. It was a very hot day and night, and they had a hammock outside made of barrel staves with a rope run through it, and I had a light blanket on there and I rested out there between times and I stayed there two days until my brother-in-law came up and said, "What's the matter? Haven't you finished yet?"

I said. "Oh, yes, we have been finished for a day."

"Well, why didn't you come home?"

"Because I thought you would have enough interest in me to come up with a horse and carriage and I would get a ride home."

"If I had known that, I would have let you stay up here all summer before I came after you, because then you could have walked home."

I must say that these activities increased my prestige with my brother-in-law, because I had others in the remote districts, and you know what I mean when there are country calls. On one occasion, a call came in and the doctor was in Belvidere—a boy with a broken leg above the knee. I went to see him and placed him in a Buck's extension. When the doctor came home I explained what had been done, and that he should go to see him, and to my surprise the patient said when we came in that "he didn't want that Kid Doctor anymore"—but he made a fine recovery and is a very capable lawyer at this time, with no limp when he walks.

My introduction to the study of typhoid fever was a patient who lived on the Hill. I could reach this house by walking a good mile, or up the steps (280) twice a day for morning and evening temperature records and the sponge bath twice a day. This patient could not afford a nurse, but the daughter, I learned

later, grew up and became a trained nurse. Still the Lord shined on my efforts, and the patient recovered.

The instructions of my brother-in-law were unique, I thought, at the time, because every one of the calls he sent me on that summer and the later summers, he always handed me his little case, a little black case which had some calomel tablets in it, and quinine tablets, and migrain tablets, tablets of Dover's Powder, compound cathartic pills, and a small bottle of tincture of aconite.

He had another grip there with about a hundred or more different formulas in it, and I used to ask him if I couldn't have that grip. I was sure I could treat them out of that array better than out of his little handbag, but he said, "When you learn what these medicines can do you will have learned a lot of medicine." My later years in practice have proved the wisdom of his instruction.

After my graduation in June I was walking up State Street in Trenton and met Dr. Frank Chattin, eye man in Newark, a resident in Mercer Hospital, and he asked about the classmates we both had known at college. He also mentioned the State Board examination and I said I might take it in the fall. He said, "By all means take it now—there are so many things you will remember now that in the fall will be stale and you may not be able to answer." I traced my steps home and borrowed the money to go to Camden, New Jersey, to interview Dr. Godfrey, who was then secretary of the Board. It appeared that the Board was to meet only two days later and they had a ruling against accepting any last-minute applications, the reason being that they did not have time then to examine the credentials to see if the applicant was really qualified.

I said, "Well, why not let me take the examinations pending your examination of my credentials and, if they are not sufficient, you don't need to issue the license to practice; but I have gone over the requirements for the State Board and I am positive that I could pass and my credentials are adequate to take care of it."

He said, "That wouldn't do and the only thing you can do would be to pay your $25 fee and take it in the fall."

Well, I paid my entrance fee, and on my way back, I became more and more instilled with the idea that I wanted to take the examination, so the next morning, going uptown near the Mechanics Bank, I ran into Senator Hutchison, who was then the Senator for Mercer County, and I said to him, "Senator, do you know anyone on the Medical Board of Examiners?"

He said, "I don't know a person, but I do have a speaking acquaintance with Dr. Wilbur, from Asbury Park."

Well, I took him in the bank and I explained everything and asked if he wouldn't give me a letter of introduction to him, which he did; so that night (the Board met the next morning) I found out that they met in the Trenton House, in Room 100. I went up and rapped on the door, and who should come to the door but Dr. Godfrey, and he wanted to know what I wanted, because, he said, "You know, you won't be allowed to take this examination."

I said I realized that but I had a letter of introduction to Dr. Wilbur, and I thought maybe I would like to present it. He said, "Dr. Wilbur is in the conference, and I don't believe he can see you."

Wilbur must have heard my voice and the mentioning of his name, and he came to the door and I said, "Are you Dr. Wilbur?"

He said, "I am."

I said, "I have a letter of introduction to you from Senator Hutchison. I thought maybe you might read it."

He said, "I will," and I handed it to him.

He read it and he said, "You be there tomorrow morning at eight o'clock."

I was there, and when I saw the man who was giving gynecology and obstetrics was Dr. Godfrey, I thought I had better take it in the fall, for I would anyway, but, fortunately for me, I went by all right and my license to practice is dated July 5, 1899.

It has been my purpose in this talk to try to entertain as well as give you inside information on some political aspects of my career. Coming to my home town in October, 1899, opening an office at 413 East State Street, formerly occupied by Dr. John Woolverton, a past president of The Medical Society of New Jersey—1862 (the fourth from Trenton). For the first thirteen days my diary reveals a patient every day, and then no more for 28 days. The superstition in my make-up came to the surface and I was very much inclined to remove myself from 413—but before I arrived at a decision there were a few emergencies and I continued.

It was necessary for me to consider how I could pay my office rent and so I increased my endeavors to become City Physician, which paid $300.00 yearly. I had started just after opening my office by doing a house-to-house canvass of voters, whether Republican, Democrat, or Prohibition—for the Republican organization dominated in the precinct in which I resided. Control of Trenton politically, however, was Democratic and the City Physicians were Democrats, so you see it was necessary

to have a change of government for me to have even a chance. There were fourteen wards, two councilmen from each ward, and the political count was eighteen Democrats and ten Republicans. If the Republicans were successful in the spring election all the offices from city clerk to dog catcher would be appointed, City Physician included.

If it was possible for me to be named City Physician, it was necessary for me to overcome the complimentary vote given to the Republican aspirants at the last election, which was ten votes, so I conceived the idea of a wheel diagram. By interviewing my friends, whose names I placed around the rim, and then contacting their friends, whose names I placed on the spokes of the wheel, I was able to get to the hub, or City Committee with satisfactory results. When it was time to interview the City Organization they had a good preview of my political friends, and when the Republican Caucus was held, I was one of the fortunate appointees and my office rent, $25.00 a month, assured until I was able to glean a sufficient practice. This appointment was in 1900. My professional visits were made on a borrowed bicycle and I was wondering how I could get a horse and carriage.

I made a careful inquiry and notation of all the city patients as to vaccination, and using this as a basis for estimating the citizens of Trenton, with a liberal allowance, was sure there were innumerable residents not vaccinated, subject to smallpox, and if it came to our city would mean untold suffering and a large financial loss to the merchants, as people would not go to the stores. At this time a book agent interviewed me and I bought Albutt's *System of Medicine,* on the installment plan, which had an excellent article on the relative value of vaccination, with statistics showing the numerous cases in the armies of the French and German, as compared with the British, where vaccination was compulsory.

Then I had two friends, Hugh Kelly and Charlie Crozier, and we used to sojourn in the evenings at a restaurant where they didn't always put out ice cream sodas. Hughie Kelly wrote the special articles for the Trenton *Sun-Advertiser* and the Trenton *Times,* and while we were imbibing a little of the camel's milk, I told him about the great number of people who were not vaccinated in the City of Trenton, and I thought that they should be so that we would not have an epidemic of smallpox.

He said, "Well, Doctor, you should go before the Board of Health."

I said, "How am I going to get before the Board of Health? I don't want to be sick."

He said, "I will get you before the Board of Health," and he did.

I gave them what I thought was an excellent explanation why those people should be vaccinated in the city of Trenton, but it didn't register.

I watched the Philadelphia papers pretty closely because Philadelphia always has some smallpox, and I thought that if anything did happen, I might bring that to the attention of the people in Trenton so that they might show us some way out of this difficulty.

When I was in college, it was my fortune to have a friend who was—well, I don't think they have any more of those competitions, but he was the heel-and-toe walker, the intercollegiate champion, and he had a residency in the Contagious Hospital in Philadelphia, and I used to visit him at times and he it was who gave me an opportunity to see something of scarlet fever, and diphtheria, and smallpox.

A few weeks after my appearance before the Board of Health, the doctor of the Board (an excellent physician) called me and wanted to know if I would see a case of smallpox with him. I remained in that home on Elmer Street until he called the Police Department to control the quarantine. He notified the Board of Health and they sent for the two City Physicians and instructed us to vaccinate all who presented themselves at the City Hall; for this we were paid a little extra; and that made it possible for me to buy a horse and wagon, and gave me a little prestige for my advocacy of a city-wide vaccination, which still exists in Trenton.

It gives me great pleasure to welcome back our men who left their practices and positions, as the case may be, and answered the nation's call in the hour of a very grave crisis.

We are all intensely proud of the magnificent contributions by our colleagues during the war. The unsurpassed record of recoveries of the wounded and stricken speaks for itself. The medical men of the military forces have brought great renown to our whole profession and we appreciate it and are proud of them. We shall demonstrate that appreciation by helping, wherever we can, the reestablishment of the veterans in their peacetime careers.

Perhaps you may think this is a singular address for your president. I have looked over a large number of the addresses by past presidents who have attained prominence by their scientific abilities and have made scientific addresses, but myself, just a physician, specializing in surgery, and doing the things a surgeon is called upon to do. I felt it was nothing more than honest that I should give you an

account of my stewardship as a physician and member of this most honorable body, The Medical Society of New Jersey. (Applause.)

PAST PRESIDENT ALEXANDER: The sun is setting as far as my year as President of the State Society is concerned, and I want to take this opportunity to thank the various officers and committee members, and the rank and file of organized medicine, for the help that they have given me during the past year. Without their assistance very little could have been accomplished.

This has been a trying year. The war is over and many of our doctors are coming back. Tasks were imposed upon our members unheard of in years gone by. We have tried to meet these problems as they rose, and I think fairly successfully, and, as time goes on, further progress will be made in the meeting and solving of these problems.

I want to thank you again for everything you have done to make my administration successful as you may feel it has been. (Applause.)

Now a motion to adjourn sine die is in order.

DR. ALTER: I so move.

(The motion was regularly seconded, was put to a vote and carried. Thereupon the House adjourned sine die at three forty-five o'clock.)

TRANSACTIONS OF

THE WOMAN'S AUXILIARY

TO

THE MEDICAL SOCIETY OF NEW JERSEY

I. PRECONVENTION BOARD MEETING

The preconvention meeting of the Board of The Woman's Auxiliary to The Medical Society of New Jersey was held at the Claridge Hotel, Atlantic City, on May 21, 1946. The meeting was called to order by the president, Mrs. William E. Dodd, and after a roll-call (see page 25) and the approval of the minutes, the treasurer, Mrs. T. P. McConaghy, submitted her statement.

Treasurer's report showed $245.80 in the emergency fund and $780.28 in the general fund; a total of $1026.08. The statement was filed for audit.

The corresponding secretary, Mrs. Banks S. Baker, read the following communications:

1. Letters from Senator Mathis and Representative Savage regarding S-95.

2. A telegram and letter from Mrs. Alfred L. Madden, president-elect of the New York Auxiliary, regarding members at large.

3. A letter from Mrs. S. Harry Ross, president-elect of the South Carolina Auxiliary, requesting a copy of Mrs. Dodd's acceptance speech and a list of our aims and ambitions.

4. A letter from Mrs. Edith L. Madden advising that Dr. Harrold A. Murray, State Chairman of the American Academy of Pediatrics, had requested an opportunity to speak to us at 11 a. m. on May 22.

5. A letter from Mrs. David W. Thomas, National President, stating that she would be unable to attend this meeting because of illness.

Mrs. McConaghy moved that a letter be sent to Mrs. Thomas expressing our regrets. Seconded by Mrs. Van Ness and carried.

REPORT OF THE PRESIDENT

Mrs. Floyd A. Shimer, second vice-president, was asked to take the chair during the presentation of the president's report. Mrs. Epler moved that the report of our president be accepted with thanks. Seconded by Mrs. R. J. McDonald and carried.

REPORTS OF COMMITTEE CHAIRMEN

Mrs. J. Howard Hornberger moved that the reports of committee chairmen be accepted at the completion of the readings.

Reports were submitted by the following committee chairmen:

Bulletin	Mrs. Floyd A Shimer
Convention	Mrs. Allman for Mrs. Mason
Credentials	Mrs. H. Donald Cowlbeck reported 58 registered, 26 present at the meeting
Finance	Mrs. Chester I. Ulmer
Hygeia	Mrs. Samuel Alexander
Legislation	Mrs. Max L. Weimann
Medical History	Mrs. S. H. Jessurun
Organization	Mrs. J. Howard Hornberger
Program	No report
Public Relations	Mrs. A. Lincoln Sherk
Widows and Orphans	Mrs. C. F. Merrill

The pending motion to accept these reports at the completion of the readings was carried.

REPORTS OF COUNTY PRESIDENTS

Mrs. J. Howard Hornberger moved that the reports of county presidents be accepted at the completion of the readings.

Reports were submitted by the following counties:

Atlantic	Mrs. Robert A. Bradley
Burlington	Mrs. M. M. Schissler (read by Mrs. Hornberger)
Camden	Mrs. Reuben L. Sharp
Essex	Mrs. S. B. Kaplan
Gloucester	Mrs. F. G. Wandall
Mercer	Mrs. H. D. Cowlbeck
Middlesex	Mrs. C. F. Merrill
Passaic	Mrs. Joseph E. Mott
Union	Mrs. H. V. Hubbard
Warren	Mrs. Floyd A. Shimer

The pending motion to accept these reports at the completion of the readings was carried.

Old Business

Mrs. Dodd advised that the report of the National Treasurer indicates that there are 842 members in our Auxiliary this year which entitles us to nine delegates and nine alternates not including the presidential delegate.

Mrs. Dodd read a letter from Essex County opposing the amendment to the Constitution effecting an increase in dues. Mrs. Van Ness stated that Essex County was not objecting to the increase in dues but to the fact that the amount was not stated. Discussion followed and Mrs. Allman moved that the proposed amendment be referred to the revisions committee and that their findings be presented on May 22. The motion was seconded and carried.

Mrs. Dodd advised that she had a full report from Mrs. Mancusi-Ungaro, who represented her at the Health Forum in Philadelphia. Mrs. Wandall reported on the morning session and Mrs. A. Lincoln Sherk spoke on the afternoon session.

New Business

Mrs. Dodd announced the resignation of Mrs. C. C. Chianese as director to permit her to serve as second vice-president. Mrs. Joseph E. Mott was appointed to fill the unexpired term of Mrs. Chianese.

The president appointed the following to serve on the auditing committee: Mrs. Chester I Ulmer, chairman; Mrs. R. J. McDonald and Mrs. J. Howard Hornberger.

Mrs. Dodd read the proposed revisions of the By-Laws to be presented at the Annual Meeting in San Francisco.

The credentials chairman, Mrs. H. Donald Cowlbeck, reported that a total of 76 members had registered, 28 were present at the meeting.

Roll Call

Roll call indicated the attendance of the following at the preconvention session:

ADVISORY BOARD

Mrs. Richard J. McDonald Mrs. J. Howard Hornberger
Mrs. David B. Allman

EXECUTIVE BOARD

Mrs. William E. Dodd Mrs. Banks S. Baker
Mrs. Frederick G. Wandall Mrs. Emanuel M. Sickel
Mrs. Floyd A. Shimer Mrs. Thomas P. McConaghy

DIRECTORS

Mrs. James H. Mason Mrs. Samuel Alexander

COMMITTEE CHAIRMEN

Mrs. Samuel H. Jessurun Mrs. J. Howard Hornberger
Mrs. Floyd A. Shimer Mrs. David B. Allman
Mrs. H. D. Cowlbeck Mrs. Don A. Epler
Mrs. James H. Mason Mrs. Richard J. McDonald
Mrs. Chester I. Ulmer Mrs. A. Lincoln Sherk
Mrs. Samuel Alexander Mrs. R. J. Faulkingham
Mrs. C. F. Merrill

COUNTY PRESIDENTS

Mrs. Robert A. Bradley Mrs. C. F. Merrill
Mrs. S. Bernard Kaplan Mrs. Joseph E. Mott
Mrs. H. D. Cowlbeck Mrs. Harry V. Hubbard
Mrs. Floyd A. Shimer

MRS. BANKS S. BAKER,
Recording Secretary.

II. THE NINETEENTH ANNUAL MEETING

The Nineteenth Annual Meeting of The Woman's Auxiliary to The Medical Society of New Jersey was held at the Hotel Traymore in Atlantic City on May 22, 1946. At 9:55 a. m., the president, Mrs. William E. Dodd, called the meeting to order. Invocation was given by the Reverend J. Stanley Wagg and the address of welcome by Mrs. Robert A. Bradley. Mrs. Wandall, the president-elect, responded to the address of welcome.

Memorial service for recently deceased members was conducted by Mrs. George A. Rogers. The late members whose memory was thus honored were:

Mrs. Henry Briody of Bergen County
Mrs. Max Danzis of Essex County
Mrs. William Friele of Hudson County
Mrs. Howard Ivins of Mercer County
Mrs. John F. Judge of Essex County
Mrs. W. Blair Stewart of Atlantic County
Mrs. A. Charles Zehnder of Essex County

Mrs. James H. Mason, convention chairman, announced the annual meeting program, which was adopted on motion. The rules of procedure were presented by the parliamentarian, Mrs. Don A. Epler, and on motion, adopted by the assembly. Mrs. David B. Allman was designated timekeeper. On motion, reading of the minutes of the eighteenth annual session was waived.

Roll Call

Roll call indicated the attendance of the following officers:

ADVISORY BOARD

Mrs. Richard J. McDonald — Mrs. Asher Yaguda
Mrs. J. Howard Hornberger — Mrs. David B. Allman

DIRECTORS

Mrs. James H. Mason — Mrs. Samuel Alexander
Mrs. Andrew C. Ruoff — Mrs. Robert B. Walker

EXECUTIVE BOARD

Mrs. William E. Dodd — Mrs. Floyd A. Shimer
Mrs. Frederick G. Wandall — Mrs. Banks S. Baker
Mrs. L. Mancusi-Ungaro — Mrs. Emanuel M. Sickel
Mrs. Thomas P. McConaghy

COMMITTEE CHAIRMEN

Mrs. Samuel H. Jessurun — Mrs. David B. Allman
Mrs. C. C. Chianese — Mrs. Don A. Epler
Mrs. Floyd A. Shimer — Mrs. L. Mancusi-Ungaro
Mrs. H. D. Cowlbeck — Mrs. Richard J. McDonald
Mrs. James H. Mason — Mrs. A. Lincoln Sherk
Mrs. Chester I. Ulmer — Mrs. R. J. Faulkingham
Mrs. Samuel Alexander — Mrs. Andrew C. Ruoff
Mrs. J. Howard Hornberger — Mrs. G. E. McDonnel
Mrs. Max L. Weimann — Mrs. C. F. Merrill

COUNTY PRESIDENTS

Mrs. Robert A. Bradley — Mrs. C. F. Merrill
Mrs. Reuben L. Sharp — Mrs. Carl H. Menge
Mrs. S. Bernard Kaplan — Mrs. Joseph E. Mott
Mrs. Edward A. Murphy — Mrs. Lancelot Ely
Mrs. H. D. Cowlbeck — Mrs. Harry V. Hubbard
Mrs. Floyd A. Shimer

Treasurer's Report

The treasurer, Mrs. T. P. McConaghy, submitted her annual report showing a balance of $1,012.13. Mrs. Chester I. Ulmer, chairman of the auditing committee, reported that the treasurer's books had been audited and found to be correct. Mrs. Mancusi-Ungaro moved that the report of the treasurer together with the attestation of the auditing committee be accepted. The motion was carried.

The corresponding secretary read a telegram from Mrs. Frank A. Bien expressing regrets at not being able to attend the meeting, and submitting her resignation as a director.

Report of the President

Mrs. Mancusi-Ungaro, first vice-president, was asked to take the chair during the presentation of the president's report. Mrs. R. J. McDonald moved that the report of our president be accepted with thanks. This motion was carried.

Reports of Officers

Mrs. Allman moved that the reports of officers be accepted as a whole at the completion of the readings.

Reports were submitted by the following officers:

President-Elect, by Mrs. Frederick G. Wandall
Second Vice-President, by Mrs. Floyd A. Shimer
Corresponding Secretary, by Mrs. Emanuel Sickel
Directors, by Mrs. James H. Mason, Mrs. Andrew C. Ruoff, Mrs. Samuel Alexander, Mrs. C. C. Chianese and Mrs. Robert B. Walker
Advisory Board, by Mrs. R. J. McDonald, Mrs. J. Howard Hornberger and Mrs. David B. Allman

The pending motion to accept the reports of officers was carried.

Reports of Standing Committees

Mrs. George Sommer moved that the reports of standing committee chairmen be accepted as a whole at the completion of the readings.

Reports were submitted by the chairmen of the following committees:

Archives and History, by Mrs. C. C. Chianese
Bulletin, by Mrs. Floyd A. Shimer
Finance, by Mrs. Chester I. Ulmer
Hygeia, by Mrs. Samuel Alexander
Legislation, by Mrs. Max L. Weimann
Medical History, by Mrs. S. H. Jessurun
Organization, by Mrs. J. Howard Hornberger
Credentials, by Mrs. H. D. Cowlbeck
Postwar Planning, by Mrs. G. E. McDonnel (report filed)
Press and Publicity, by Mrs. L. Mancusi-Ungaro
Program, by Mrs. R. J. McDonald (report filed)
Public Relations, by Mrs. A. Lincoln Sherk
Widows and Orphans, by Mrs. C. F. Merrill

The pending motion to accept the reports of Standing Committees was carried.

Introduction of Medical Society Officers

After the reading of these reports our president introduced the chairman of our advisory committee, Dr. William E. Dodd. Dr. Dodd expressed the appreciation of The Medical Society for the work which we accomplished during the past year and hoped that the chairman of every committee of The Medical Society would include the Auxiliary in his plans. Dr. Dodd introduced Dr. Frank G. Scammel, president-elect of The Medical Society.

Dr. Harrold A. Murray, state chairman of the Academy of Pediatrics, was introduced. Dr. Murray requested our assistance in the survey on child health services which is to be made in the very near future.

Report of Safety Committee

Mrs. Mancusi-Ungaro, chairman of the safety committee, submitted her report. Mrs. Asher Yaguda moved that this report be accepted with thanks. This motion was carried. Mrs. Dodd expressed her thanks to Mrs. Mancusi-Ungaro for her splendid work and discharged this committee.

Guests

Mrs. Dodd introduced Mrs. V. E. Holcombe, past-president of the Woman's Auxiliary to the American Medical Association. Mrs. Holcombe introduced Mrs. James N. Brawner of Atlanta, Georgia, a member of the executive board of the Woman's Auxiliary to the Southern Medical Society and honorary life president of the Georgia Auxiliary.

Reports of County Presidents

Mrs. J. Howard Hornberger moved that we accept the reports of county presidents as a whole at the completion of the readings.

Reports were submitted from the following counties:

Atlantic, by Mrs. Robert A. Bradley
Burlington, by Mrs. J. H. Hornberger
Camden, by Mrs. Reuben L. Sharp
Essex, by Mrs. S. B. Kaplan
Hudson, by Mrs. Edward A. Murphy
Mercer, by Mrs. H. D. Cowlbeck
Middlesex, by Mrs. C. F. Merrill
Ocean, by Mrs. Carl A. Menge
Passaic, by Mrs. Joseph E. Mott
Union, by Mrs. H. V. Hubbard
Warren, by Mrs. Floyd A. Shimer

The pending motion to accept the reports of county presidents was carried.

Announcements

Mrs. Brawner (our guest from Atlanta) informed our president that the Daughters of the American Revolution had just passed a resolution condemning efforts to socialize the practice of medicine.

Mrs. A. Haines Lippincott, state commander of the woman's field army of the American Cancer Society, urged members of the Auxiliary to see the excellent cancer exhibit at the Claridge. This exhibit may be borrowed from the Department of Health for programs. Mrs. Lippincott stated that it is very important for the wives of physicians to enter into the educational work of the Cancer Society.

Credentials

Mrs. H. Donald Cowlbeck, credentials chairman, reported 63 attending the meeting.

The meeting adjourned for luncheon and reconvened at 3:40 p. m.

Unfinished Business

Mrs. Lancelot Ely of Somerset County requested advice as to the disposition of funds still in their treasury. No action was taken inasmuch as this money does not belong to the State Auxiliary. Mrs. Ely was invited to attend our next Board meeting.

Mrs. J. Howard Hornberger, organization chairman, reported that the Cape May County Auxiliary had requested us to wait until they are ready to be re-activated.

New Business

The President read a letter from the secretary of the Monmouth County Auxiliary stating that they were inactive at the present time. Mrs. Yaguda was requested to attempt to arouse interest there and to report at the October Board meeting.

Mrs. Dodd advised that the resignation of Mrs. C. C. Chianese as a director had been accepted and that Mrs. Joseph E. Mott had been appointed to fill the unexpired term of Mrs. Chianese. Mrs. Mancusi-Ungaro moved that the appointment of Mrs. Mott as director be approved. This motion carried.

Mrs. Dodd announced that Mrs. Frank A. Bien had submitted her resignation as a director. Mrs. Van Ness moved that this vacancy be filled by the Executive Board at a later date. This motion carried.

Mrs. Frank S. Forte of Essex County was appointed to serve as a delegate to the convention of the Auxiliary to the American Medical Association.

Mrs. Dodd read a message from the national chairman regarding the following proposed revisions of the By-Laws:

Chapter IX to read:
"The presiding officer of the conference shall be the president-elect of this Auxiliary."

Mrs. Van Ness moved that our delegates be instructed to vote in the affirmative on this proposed revision. This was carried.

Chapter III to read:
"She shall also serve as presiding officer of the conference of presidents and chairmen of standing committes."

Mrs. A. J. Casselman moved that our delegates be instructed to vote in the affirmative on this proposed revision. This motion was carried.

Revisions

Mrs. Andrew C. Ruoff, chairman of revisions, submitted her annual report in which she explained the proposed revision to Chapter V covering dues. Mrs. Ruoff submitted the following revision and moved its adoption:

Each county auxillary shall pay dues to the state auxiliary at the rate of one dollar per capita, twenty-five cents of which shall go to the national auxiliary.

Seconded by Mrs. Figurelli, this motion was carried.

Nominating Committee

In accordance with Chapter I, Section 1, of the by-laws the following were nominated to serve on the nominating committee:

Mrs. William E. Dodd, Chairman
Mrs. Reuben L. Sharp
Mrs. Daniel C. Kavanaugh
Mrs. Joseph E. Mott
Mrs. C. C. Chianese

Mrs. Yaguda moved that those members be elected to serve on the nominating committee for the year 1946-1947. Seconded by Mrs. David B. Allman, this motion was carried.

Election of Officers

Mrs. David B. Allman, chairman of the nominating committee, submitted names of the following candidates:

President-elect, Mrs. Lodovico Mancusi-Ungaro
First vice-president, Mrs. Andrew C. Ruoff
Second vice-president, Mrs. C. Chester Chianese
Recording Secretary, Mrs. Banks S. Baker
Treasurer, Mrs. Thomas P. McConaghy
Directors, Mrs. Chester I. Ulmer and Mrs. Abraham Jaffin

Mrs. Ulmer moved that the recording secretary cast a unanimous ballot for these nominees. This motion was unanimously carried and the above-named candidates were declared elected.

Resolutions

Mrs. R. J. Faulkingham, chairman of resolutions, presented the following resolution and moved its adoption:

Resolved, That the Woman's Auxiliary to The Medical Society of New Jersey extend its profound thanks to Mrs. James H. Mason, general chairman of the convention, and her committees, for the careful handling of every detail for the comfort and happiness of the officers, delegates, members and visitors to this convention;

That the corresponding secretary be instructed to express appreciation to the hostess county, Atlantic, for the many courtesies extended during the convention;

That the corresponding secretary be further instructed to express grateful appreciation to Mr. Rundstron, assistant manager of the Traymore, for the many courtesies extended during the convention;

That the corresponding secretary acknowledge to the officers, chairmen of state committees and county presidents the appreciation of this convention for their reports, which have ben so complete and indicative of results.

Seconded by Mrs. Ulmer, the resolution was unanimously adopted.

Credentials Report

Mrs. H. Donald Cowlbeck, chairman on credentials, reported 192 registered, 88 attending the meeting. Mrs. Merrill moved that the report of the credentials chairman be accepted. This motion was carried.

Reading Committee

Mrs. H. Roy Van Ness moved that the minutes of the meeting be referred to a reading committee for approval. This motion was carried. Mrs. Dodd appointed Mrs. Asher Yaguda and Mrs. Mancusi-Ungaro to serve on this committee.

Publicity

Mrs. Mancusi-Ungaro advised that Miss Wilkie Hughes would like to publicize the work being done by Burlington and Atlantic Counties for nurses in the *Nursing Journal.* This matter will be referred to our advisory chairman for his consideration.

Installation of Officers

The president, Mrs. Dodd, installed the newly elected officers and presented the gavel to Mrs. Frederick G. Wandall, the incoming president.

Mrs. Wandall requested that her executive officers meet with her immediately following this meeting.

There being no further business the President declared the Nineteenth Annual Meeting adjourned.

MRS. BANKS S. BAKER,
Recording Secretary.

III. POSTCONVENTION BOARD MEETING

The postconvention meeting of the Board was held at the Claridge Hotel on May 23, 1946. The meeting was called to order by the president, Mrs. Frederick G. Wandall. Roll call revealed attendance of the following officers:

ADVISORY BOARD

Mrs. J. Howard Hornberger — Mrs. David B. Allman
Mrs. Asher Yaguda — Mrs. William E. Dodd

EXECUTIVE BOARD

Mrs. Frederick G. Wandall — Mrs. Chester I. Ulmer
Mrs. L. Mancusi-Ungaro — Mrs. Banks S. Baker
Mrs. Andrew C. Ruoff — Mrs. Thomas P. McConaghy

DIRECTORS

Mrs. S. H. Jessurun — Mrs. Chester I. Ulmer
Mrs. Samuel Alexander — Mrs. Joseph E. Mott
Mrs. A. E. Jaffin

COUNTY PRESIDENTS

Mrs. Charles Hyman — Mrs. A. Lincoln Sherk
Mrs. Dean LeFavor — Mrs. Frank S. Forte
Mrs. E. A. Murphy

COMMITTEE CHAIRMEN

Mrs. S. H. Jessurun — Mrs. Joseph E. Mott
Mrs. David B. Allman — Mrs. William E. Dodd
Mrs. D. C. Reyner — Mrs. Asher Yaguda
Mrs. E. A. Murphy — Mrs. Andrew C. Ruoff
Mrs. C. F. Merrill

After roll call, minutes of the preconvention Board meeting were approved as read.

The treasurer, Mrs. T. P. McConaghy, submitted a report showing a balance of $1,005.33. This report was received and filed for audit.

The corresponding secretary read a letter from the eidtor of the JOURNAL concerning the form of the reports of County Presidents and Officers. This letter was referred to Mrs. Theodore Robie, chairman of press and publicity.

Mrs. Wandall announced her committee appointments and introduced the chairmen present.

Mrs. Dodd nominated Mrs. S. H. Jessurun as director to fill the unexpired term of Mrs. Bien. This nomination was approved.

The treasurer, Mrs. T. P. McConaghy, requested instructions about the money we have received from The Medical Society. It was suggested that Mrs. McConaghy meet with the finance chairman, Mrs. G. E. McDonnel, and report at the next meeting.

Mrs. David B. Allman moved that the following members be referred to the organization chairman for communication and verification as members at large. This was carried.

Mrs. Stewart F. Alexander
Mrs. Floyd Keir
Mrs. Allan J. Stolow

Mrs. Hornberger moved that the corresponding secretary write to Somerset County requesting that they advise us as to their status; also that they send in their official notification if they wish to disband, together with the names of members who might wish to become members-at-large if their society is disbanded. This was carried.

The president, Mrs. Wandall, requested that all county presidents send the names and addresses of all officers and committee chairmen to Trenton by July first.

The president set September 5 for the Third Annual Conference. This conference is for the instruction of state and county officers, especially committee chairmen. Notices will be sent in time.

MRS. BANKS S. BAKER,
Recording Secretary.

IV. TREASURER'S REPORT

		Medical Society	*Emergency Account*	*General Account*	*Total*
May 23, 1945, balance on hand			$192.96	$230.98	$ 423.94
RECEIPTS					
Dues	$529.40				
Sale index cards	2.50				
Sale Hand Books	.75				
Received from Medical Society	599.73	$599.73	52.94	479.71	1,132.38
		$599.73	$245.90	$710.69	$1,556.32
DISBURSEMENTS					
Mrs. Allman—Stationery	$ 1.95				
Dues N. J. Health and Sanitary Assn.	3.00				
Treasurer's Bond	5.00				
National Dues	210.50				
President's Pin	32.00				
Stationery	14.75				
Medical Society Office postage	1.50				
President's expenses	244.55				
Treasurer's expenses	4.00				
Nominating Committee	2.67				
Credentials Committee	3.95				
Bulletin Committee	1.50				
Publicity Committee	8.82				
Four Guest Convention luncheons	10.00	$190.08		$354.11	$ 544.19
May 22, 1946, balance on hand		$409.65	$245.90	$356.58	$1,012.13

Investments on hand include two $100 Series F-U. S. War Bonds due in twelve years, Serial 4C742366F issued September, 1943, and Serial C1065402F issued June, 1944, to the Woman's Auxiliary to The Medical Society of New Jersey.

Respectfully submitted,

MRS. THOS. P. MCCONAGHY, Treasurer.

AUDIT

We, the auditing committee, have checked our treasurer's books and find they are accurate.

(Signed)
(Mrs. R. J.) ISABEL M. McDONALD
(Mrs. J. H.) LEAH M. HORNBERGER
(Mrs. C. I.) GRACE M. ULMER

V. ANNUAL REPORT OF OUTGOING PRESIDENT

With a feeling of pleasure and yet with regret, I have the honor to submit herewith the report of your president since taking office in June, 1945.

On June 19, I presided at the second Annual Conference of state chairmen and county presidents in Trenton. The four Board meetings, October, January, March and May, were conducted to the best of my ability. Meetings were held frequently with the chairmen of auxiliary committees as well as with the chairman of the advisory board, Dr. William E. Dodd, the public relations chairman of the State Medical Society, Dr. Samuel Sica, and with Dr. Henry A. Davidson, the Editor, on problems of publicity.

It was a privilege to attend the Welfare meetings of The New Jersey Medical Society in October and January. I represented the Auxiliary at a health institute in New Brunswick, sponsored by the New Jersey State Federation of Woman's Clubs in October and at the first Home Safety Forum sponsored by the woman's division of the Newark Safety Council in February.

Attending the second Annual Conference of presidents and presidents-elect of the Woman's Auxiliary to the American Medical Association in Chicago in December, 1945, was most interesting and constructive. It was an honor to represent you at the district councilor meeting of the Woman's Auxiliary to the Philadelphia County Medical Society held in Philadelphia in January, and at the Presidents' Day, of the Contemporary of Newark.

Twenty-one official visits were made to the component County Auxiliaries. It is with regret that I must report unfavorable results from a visit to Cape May County where it was hoped to reorganize the Auxiliary and from a visit to Somerset County which needs reactivation.

Ours is not a large organization when compared with others, yet the correspondence is not small. One hundred and nineteen communications were received and two hundred and eighty letters were sent out. Numerous telephone conversations were necessary to conduct the business during the year. Regular news letters have been received from the Council on Medical Service and Public Relations of the American Medical Association presenting the latest action on medical legislation. Eight messages were written for the JOURNAL.

I would like to recommend that there be greater attendance and more publicity given to the annual conference of committee chairmen and county presidents; and that regional cochairmen be appointed to ease the work of the committee chairmen.

To give real service you must add something which cannot be bought or measured with money, and that is sincerity and interest. This was evident in your whole-hearted response to my requests and which I know you will accord my successor, Mrs. Frederick G. Wandall.

In closing this annual report of the nineteenth President of the Woman's Auxiliary to The Medical Society of New Jersey, I should like to thank the officers, directors, committee chairmen, our advisory committee, county presidents and Mrs. Madden and her staff, who have all worked together to make the activities of this Auxiliary and to bring a measure of success to my administration.

Success is not reached at a single bound,
But we build together the ladder by which we rise
From the lowly earth to the vaulted skies,
As we mount to its summit round by round.

MRS. WILLIAM E. DODD,
President 1945-46.

OF MEDICINE
SEP 20 1946

THE JOURNAL

OF

THE MEDICAL SOCIETY OF NEW JERSEY

Entered as second-class matter, September 5, 1906, at the post office at Orange, New Jersey, under Act of March 3, 1879.

VOL. 43, NO. 9 SEPTEMBER, 1946 Subscriptions, $3.00 per Year
Single Copies, 30 Cents

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Place of Publication, Printing and Mailing:
12 South Day St., Orange, N. J.

Editorial and Executive Offices of the Society:
315 West State St., Trenton 8, N. J.

Send all communications to the Trenton Office,
telephone Trenton 5776

Acceptance for mailing at special rate of postage provided for in Sec. 1103, Act of Oct. 3, 1917, authorized July 29, 1918.

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STATE SOCIETY PLAN

Accident and Health Insurance

The MEDICAL SOCIETY OF NEW JERSEY has officially selected the plan of our Company for Accident and Health Insurance and the policy is now available to Society members on a Group Plan Basis.

BRIEF OUTLINE OF COVERAGE

Accidental Bodily Injury Benefits —Full monthly benefit for total disability, from FIRST DAY, limit 60 months. One-half monthly benefit for partial disability, limit 6 months. Limit of time for total and partial combined 60 months.

Sickness Benefits —Full monthly benefit for total disability commencing with EIGHTH DAY of disability, limit 12 months, house confinement not required.

Arbitration Clause —The Committee on Medical Defense and Insurance of The Medical Society of New Jersey are the SOLE arbiters in the event of any claim disagreement between Company and policyholder.

Cancellation Clause —The policy is individually non-cancellable on a group basis throughout the State for members of the Medical Society of New Jersey.

PREMIUM RATES

(Applicable to ages at entry and attained at annual renewal of insurance)
Ages shown below signify next birthday.

Monthly Benefits	Dismemberment Benefits	ANNUAL RATES* Ages up to 50	Ages 51 to 60	Ages 61 to 65
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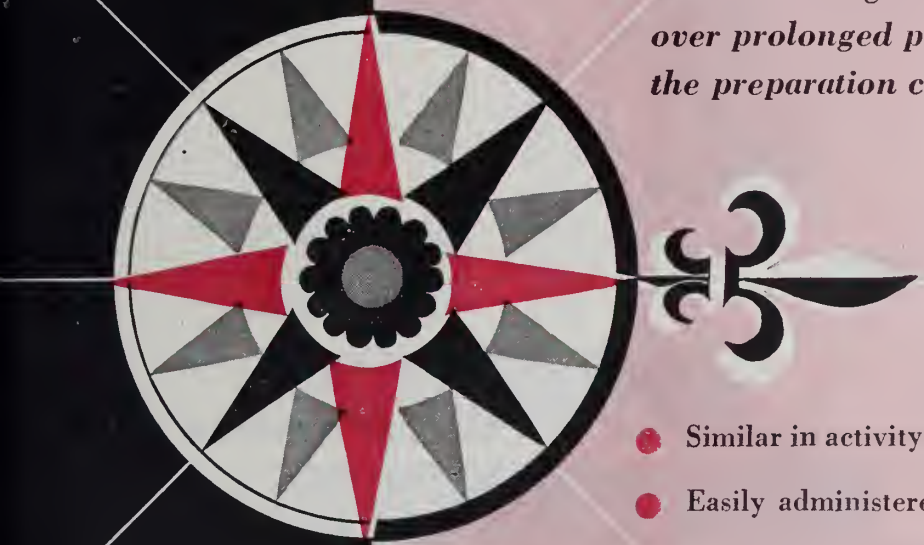
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*Hinsie, Leland E.: The Person in the Body, an Introduction to Psychosomatic Medicine, New York, W.W. Norton & Co., 1945, p. 223.

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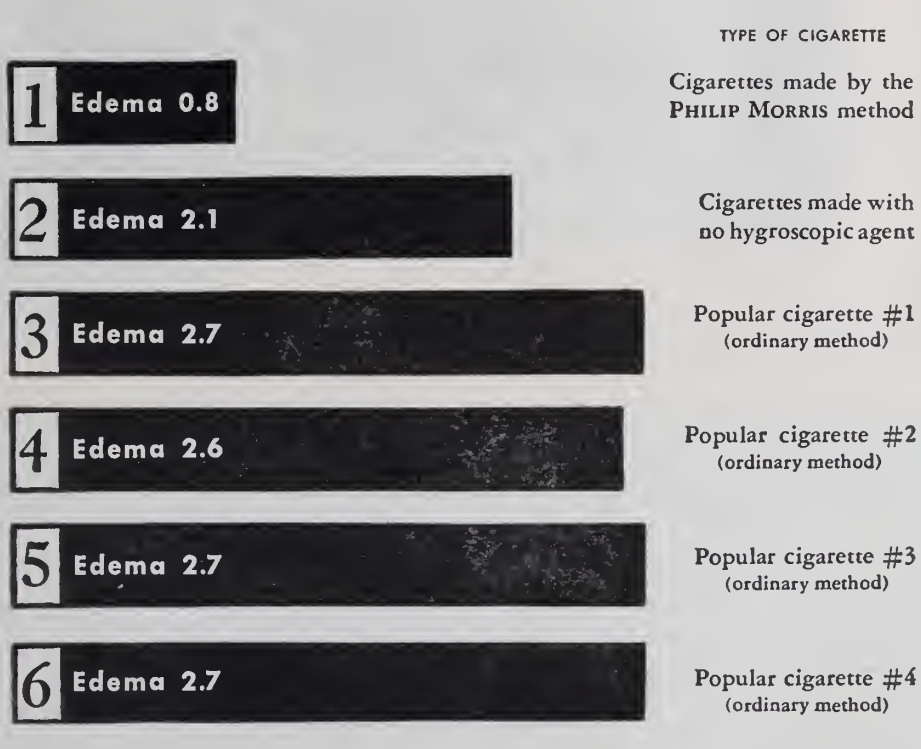
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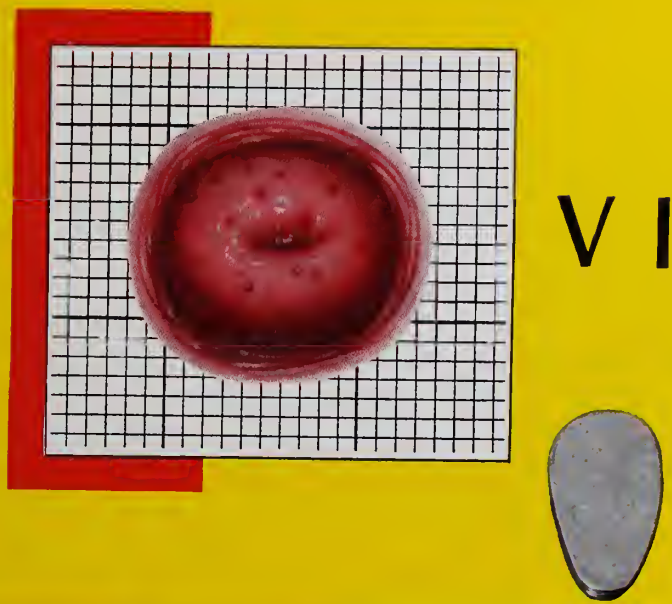
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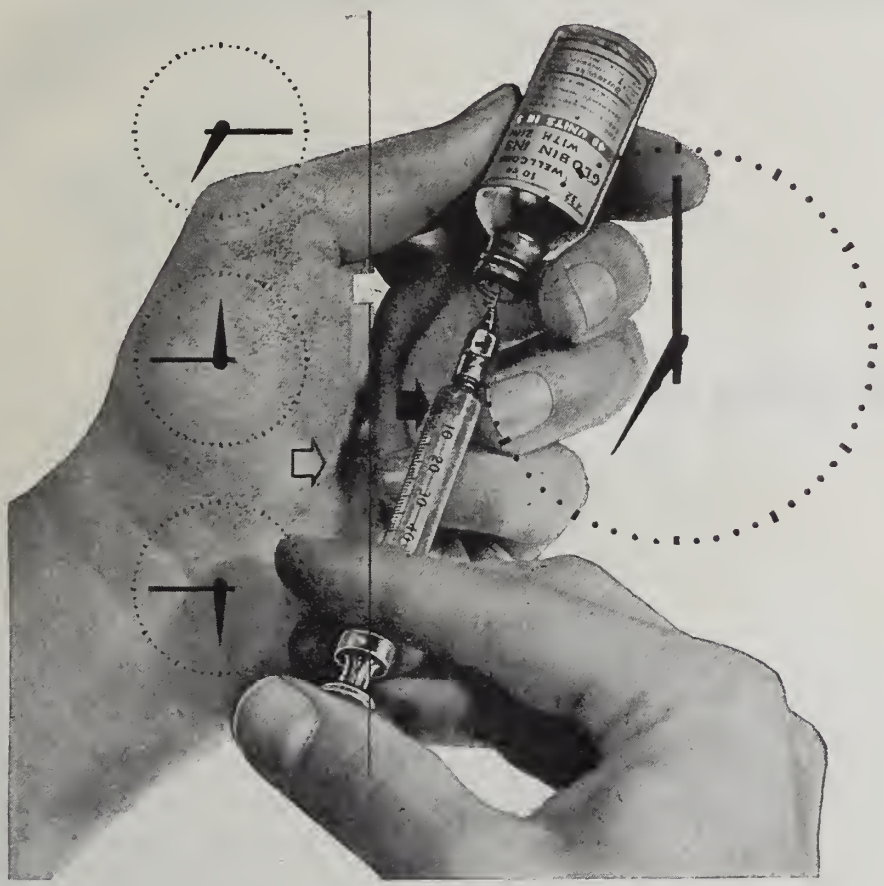
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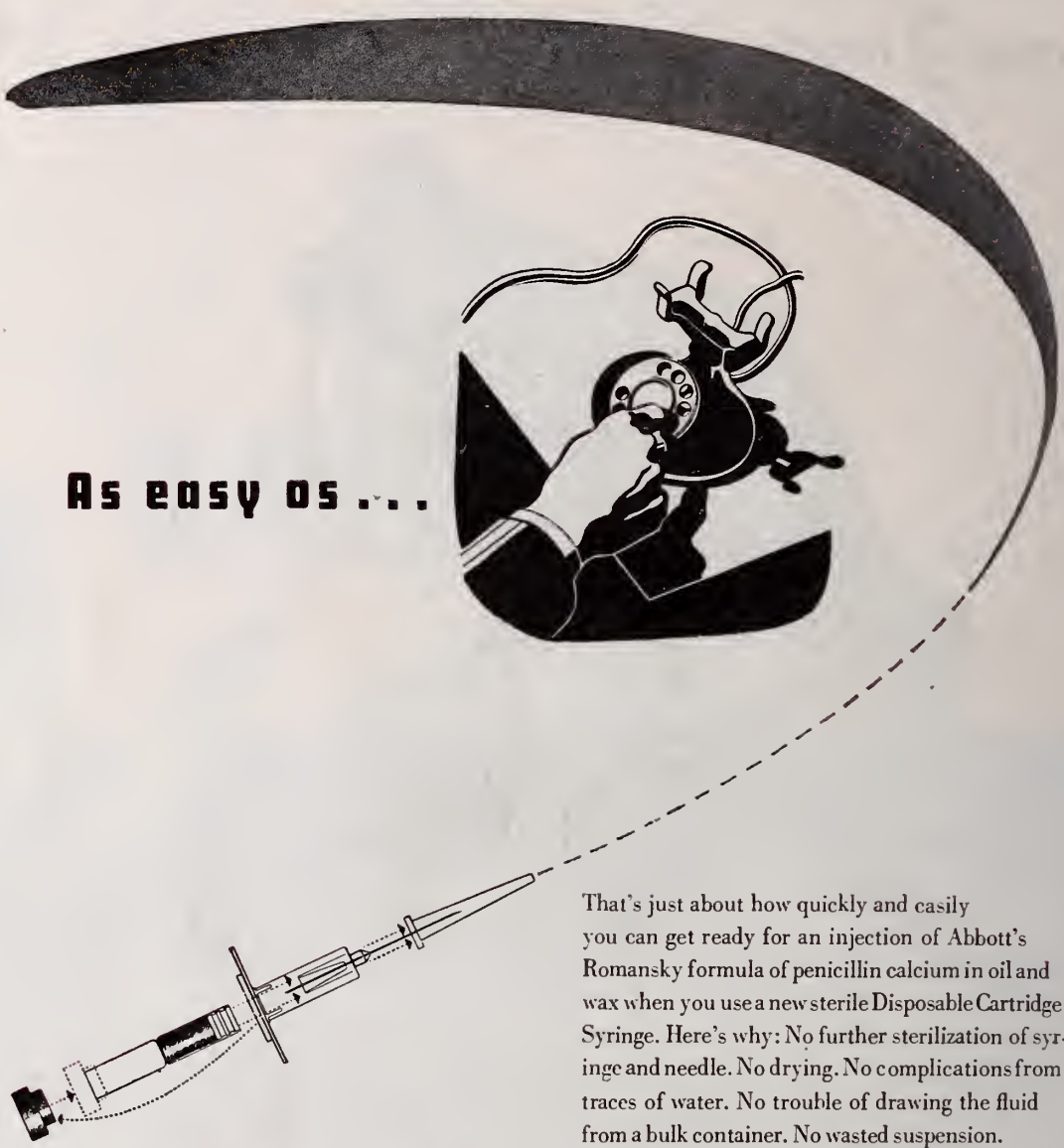
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---

[1] Tillett, W. S., Cambier, M. J., and McCormack, J. E.: The Treatment of Lobar Pneumonia and Pneumococcal Empyema with Penicillin, Bull. New York Acad. Med. *20*:142, March, 1944.

[2] Armstrong, S. H., Jr.; England, A. C., Jr.; Favour, C. B., and Scheinberg, I. H.: Anemia and Hypoproteinemia Complicating Severe Protracted Pneumonia: Treatment with Penicillin—Role of Specific Supportive Therapy in Recovery, J.A.M.A. *127*:303 (Feb. 10) 1945.

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WOLLGAST, C. F.: *The Clinical Use of Penicillin: A Report of 115 Cases Treated in an Army Hospital, Texas State J. M. 40:225 (Aug.) 1944.* FARQUHARSON R. F.; GREEY, P., & TOWNSEND, S. R.: *Results of Penicillin Therapy: A Report for the Joint Services Penicillin Committee, Canad. M. A. J. 53:1 (July) 1945.*

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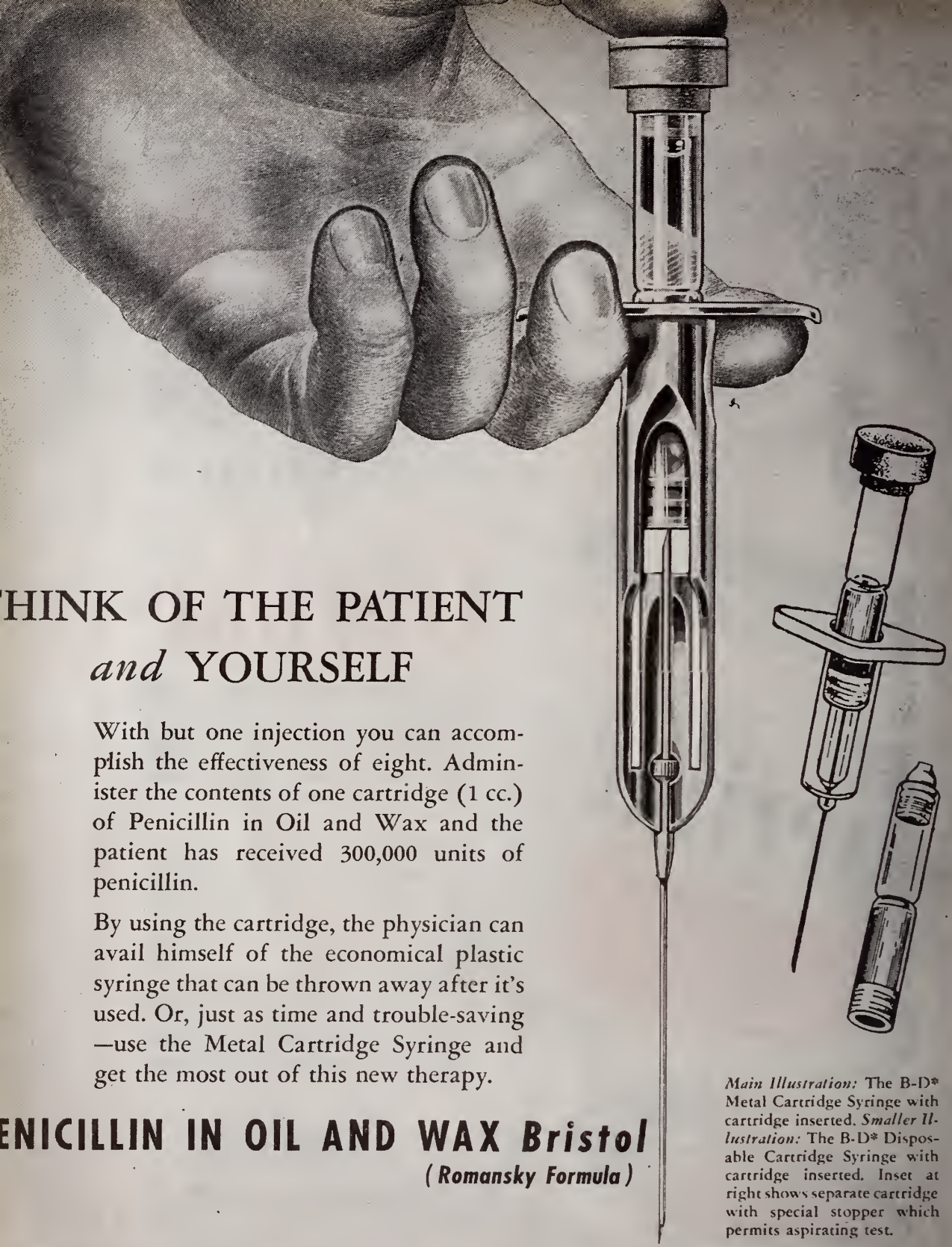
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the incidence of rickets is astonishingly high in children of *all* age groups. Examination of 230 children aged *2* to *14* years, at Johns Hopkins revealed histologic evidence of rickets in 46.5 per cent, with a high of 62 per cent in the 10 to 11 year old group.[1] Similarly of 943 seemingly "normal" pre-school children 90 per cent exhibited symptoms of rickets.[2]

Safety lies in vitamin D prophylaxis ". . . throughout the growing period."[3]

The standard by which the biologic activity of all antirachitic agents is evaluated is cod liver oil. White's Cod Liver Oil Concentrate provides the natural vitamins A and D of time-proved cod liver oil itself, in three palatable, stable, convenient dosage forms well suited for adequate protective administration from 14 days to at least 14 years.

1. Follis, R. H. Jr.; et al: Am. J. Dis. of Child., *66*:1-11 (July) 1943.

2. Moore, C. U.; et al: Am. J. Dis. of Child., *54*:1227-28 (Dec.) 1937.

3. Park, E. A.: Vitamin D Therapeutics, THE VITAMINS, A. M. A., Chicago, 1937.

White's

cod liver oil concentrate

Liquid Tablets Capsules

ACCEPTED AMERICAN MEDICAL ASSN. Council on Pharmacy and Chemistry

Ethically promoted. Council accepted. White Laboratories, Inc., Pharmaceutical Manufacturers, Newark 7, N. J.



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SIMPLE AND EFFECTIVE • Demerol hydrochloride is administered orally or by intramuscular injection. Average dose: 100 mg., when the pains become regular, repeated three or four times at intervals of from 1 to 4 hours. In analgesic power Demerol hydrochloride ranks between morphine and codeine; it also has a spasmolytic effect comparable with that of atropine, as well as a sedative action. It may also be used in conjunction with scopolamine or barbiturates for amnesia.

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An effective parasympathetic stimulant

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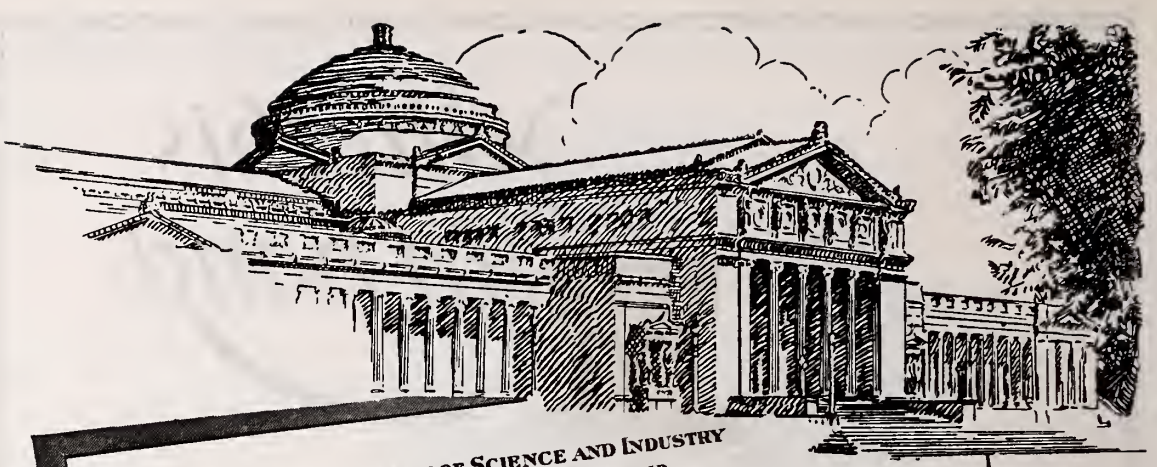
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D14



MUSEUM OF SCIENCE AND INDUSTRY
FOUNDED BY JULIUS ROSENWALD
JACKSON PARK · CHICAGO 37

August 7, 1946

Mr. C. H. Fleck, President
S. H. Camp and Company,
Jackson, Michigan

Dear Mr. Fleck:

Today marks the 10th Anniversary of the Transparent Woman exhibit and since the famous "lady" is making her permanent home in our Medical Section, we feel that the day should not be allowed to pass without some comment.

I vividly recall the premier of the Transparent Woman at Rockefeller Center in New York City before a distinguished assembly of physicians, scientists and educators. Its later tour throughout the Nation under the auspices of state and county medical societies and academies of medicine was a significant contribution to public health education. You are to be congratulated not only on your sponsorship of this important and effective exhibit but also on the ethical manner in which it was presented to the laity through the profession.

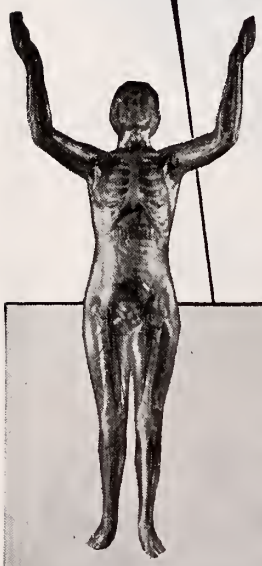
The Transparent Woman continues to be one of the major centers of interest at the museum. Practically all of the 1,026,250 visitors last year made her acquaintance and preliminary 1946 figures show the attendance running higher.

It is fitting on this 10th Anniversary of the Transparent Woman exhibit to again express our appreciation to you for your active interest in the Medical Section.

Cordially yours,

Eben J. Carey

EBEN J. CAREY, M.D., Curator,
Medical Exhibits



CAMP TRANSPARENT WOMAN EXHIBIT MARKS TENTH ANNIVERSARY

Dedicated at Rockefeller Center in 1936 by world famous figures in medicine, science and education, the *Transparent Woman* has since been viewed by some 50,000 physicians and 16,000,000 laymen. Its steady popularity in the Medical Section of the Museum of Science and Industry verifies our hope that the exhibit will continue to play its authentic role in public health education within the precepts of the medical profession.

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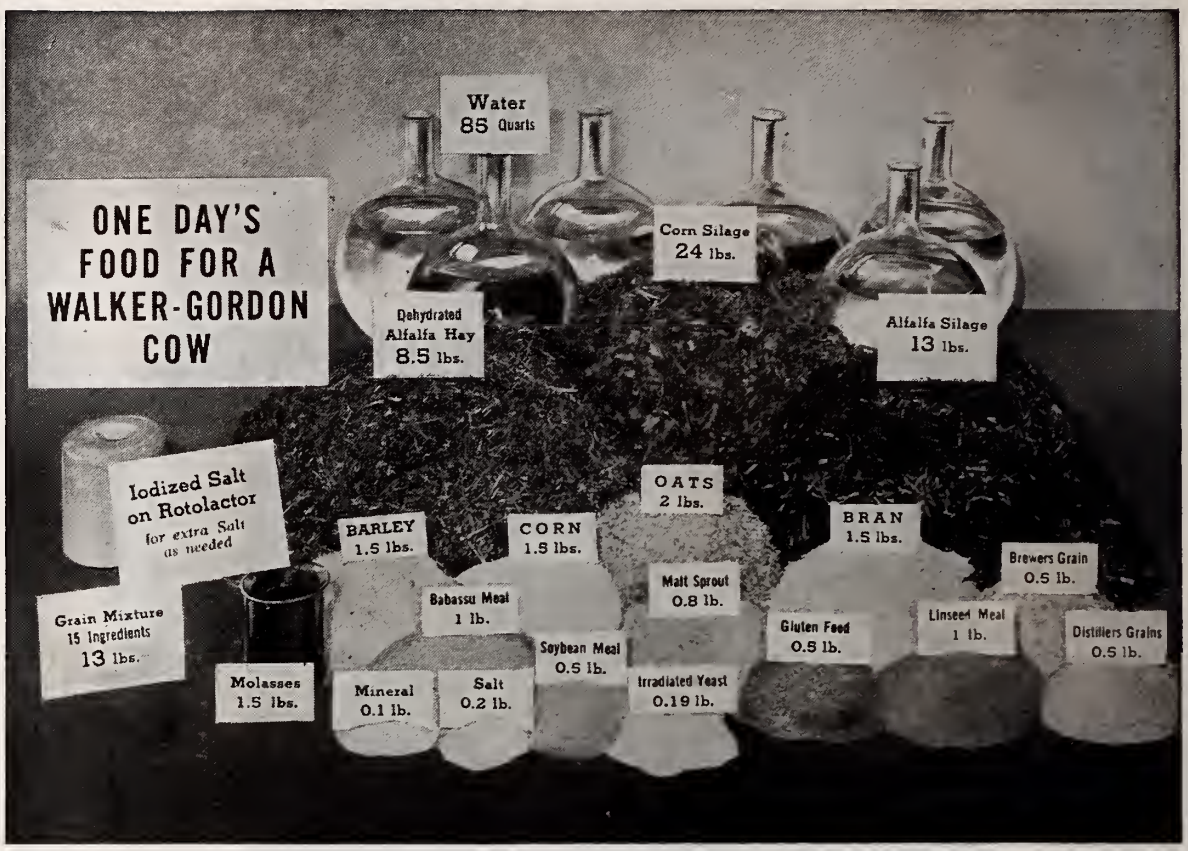
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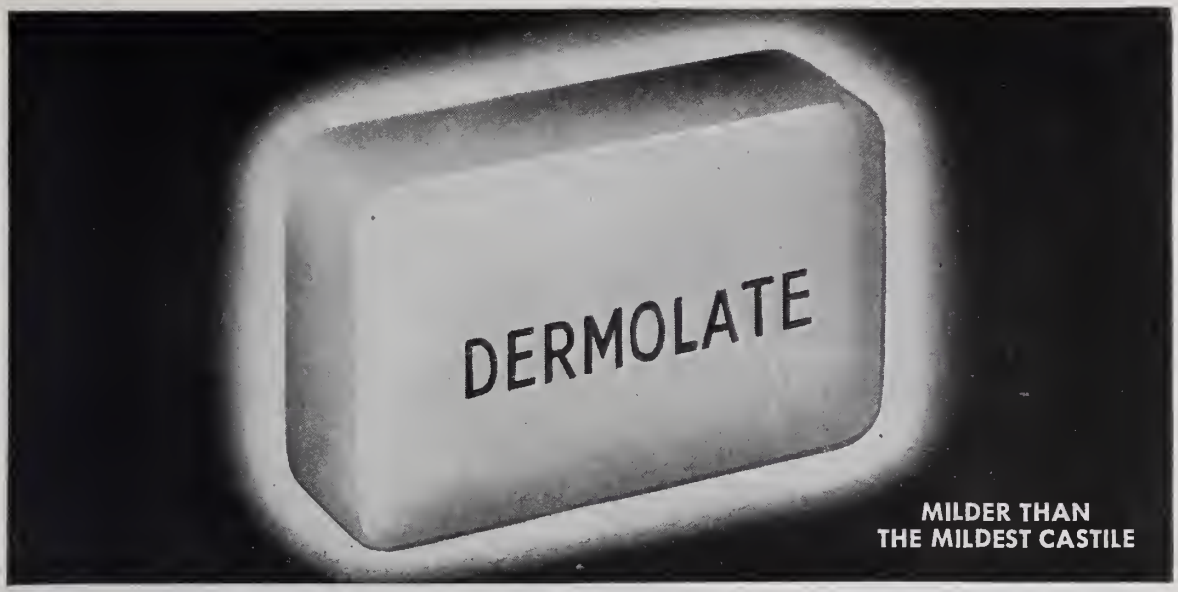
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Like a vanishing cream in cake form, but with lathering and detergent qualities

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Dermolate, retaining the non-irritating characteristics of vanishing creams, adds lather and excellent cleansing properties. It is a mixture of high-molecular-weight sulfato-octadecanoic acid, stearic acid, and the sodium salts of these preponderantly saturated fatty acids.

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Like Acidolate, Dermolate maintains its detergent properties even when used with hard water. However, it has the psychological advantage of lathering and is more convenient for routine daily use.

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1. I. H. Blank, *Arch. of Derm. and Syph.*, **39**: 811-824 (1939) May: "Action of Soap on Skin."

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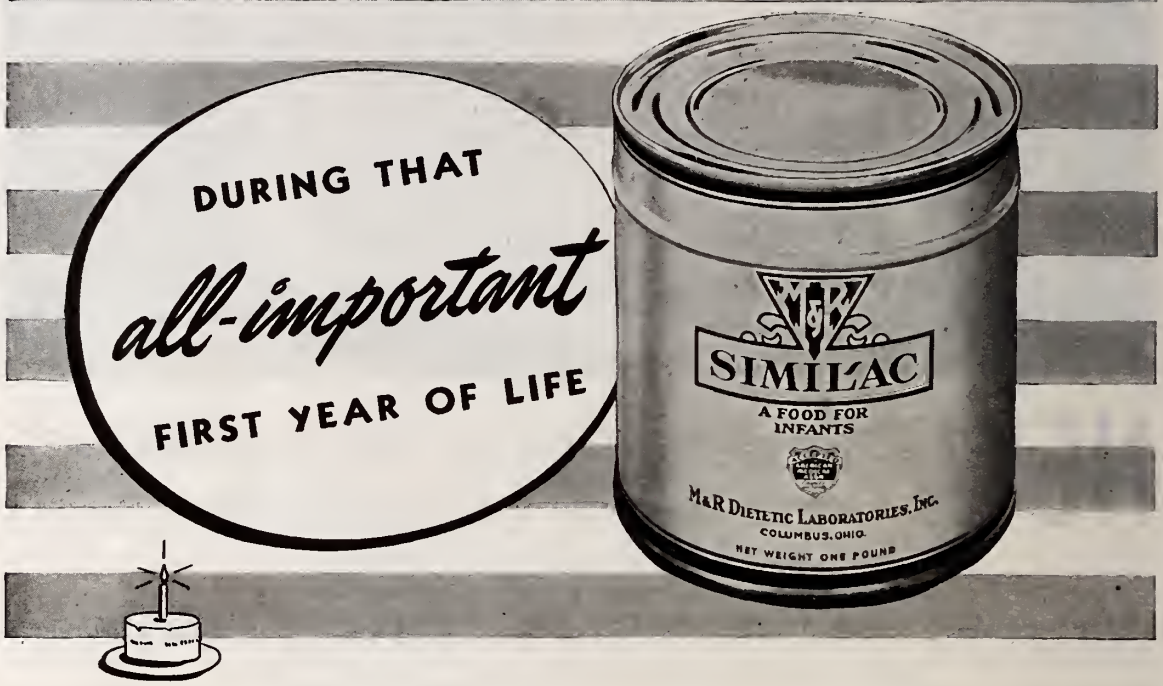
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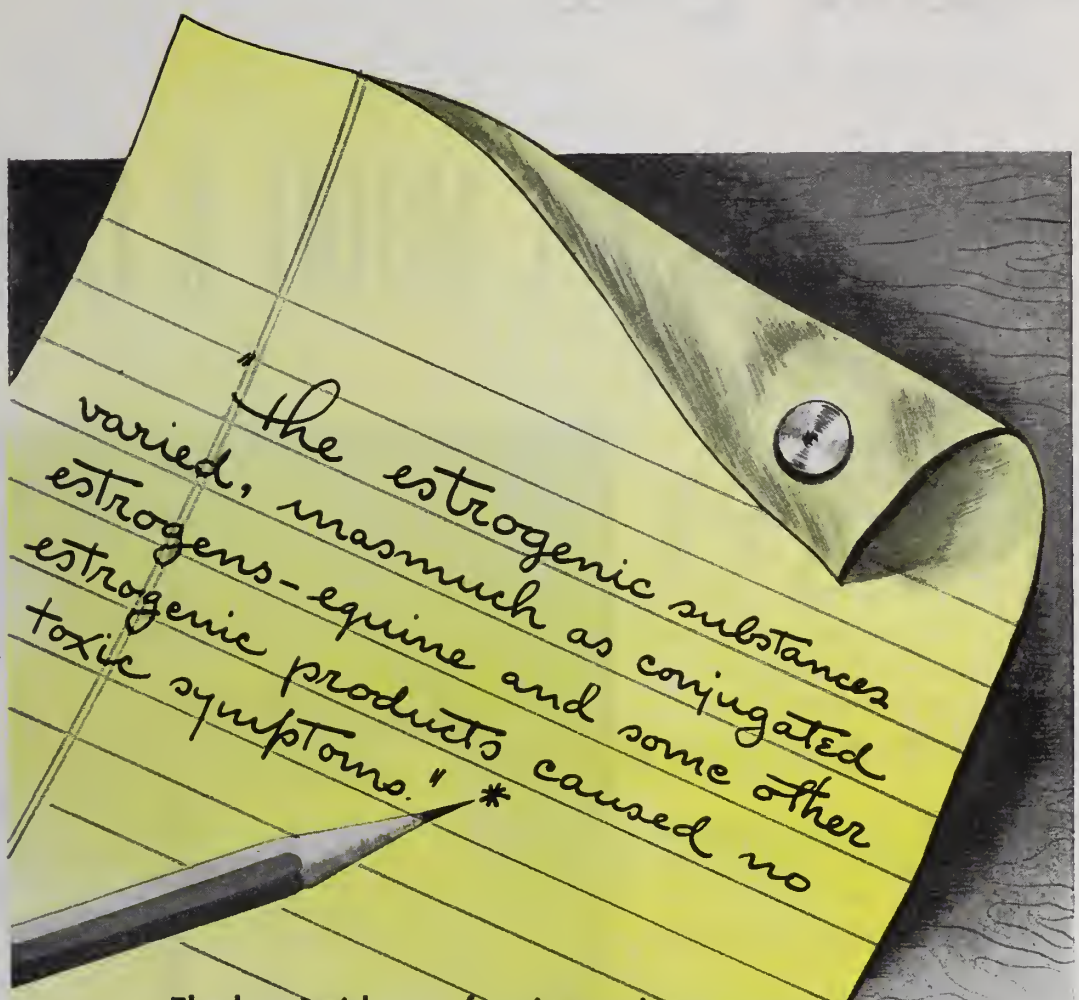
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*Harding, F. E.: Am. J. Obst. & Gynec., 51:660 (May) 1946

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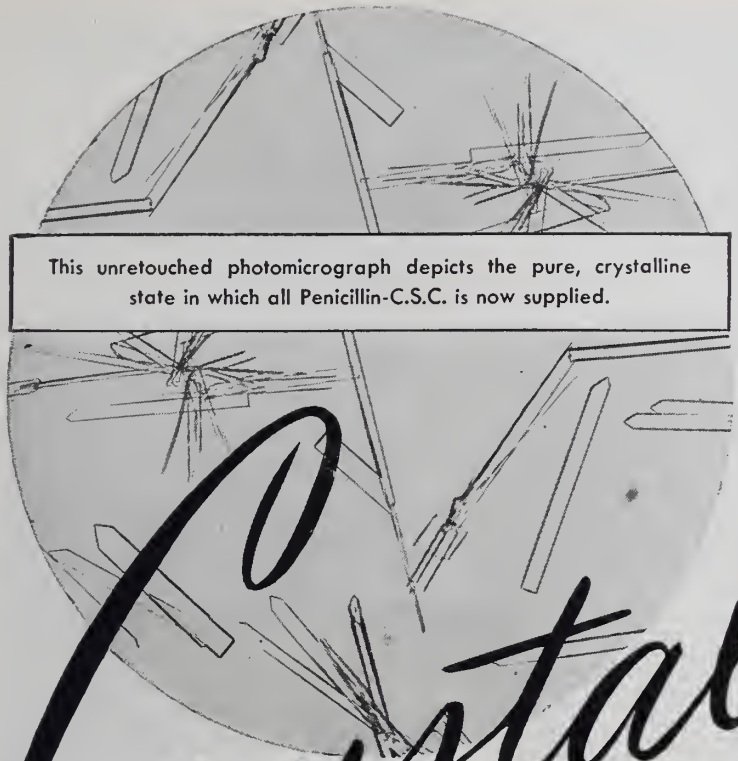
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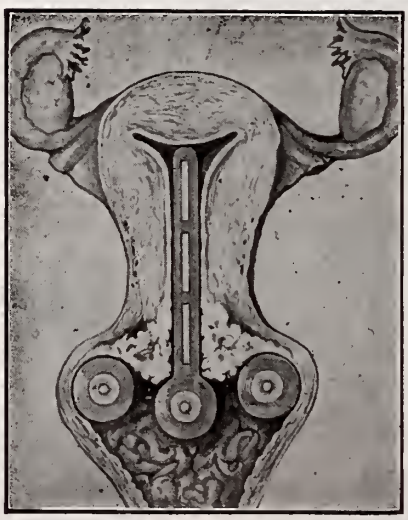
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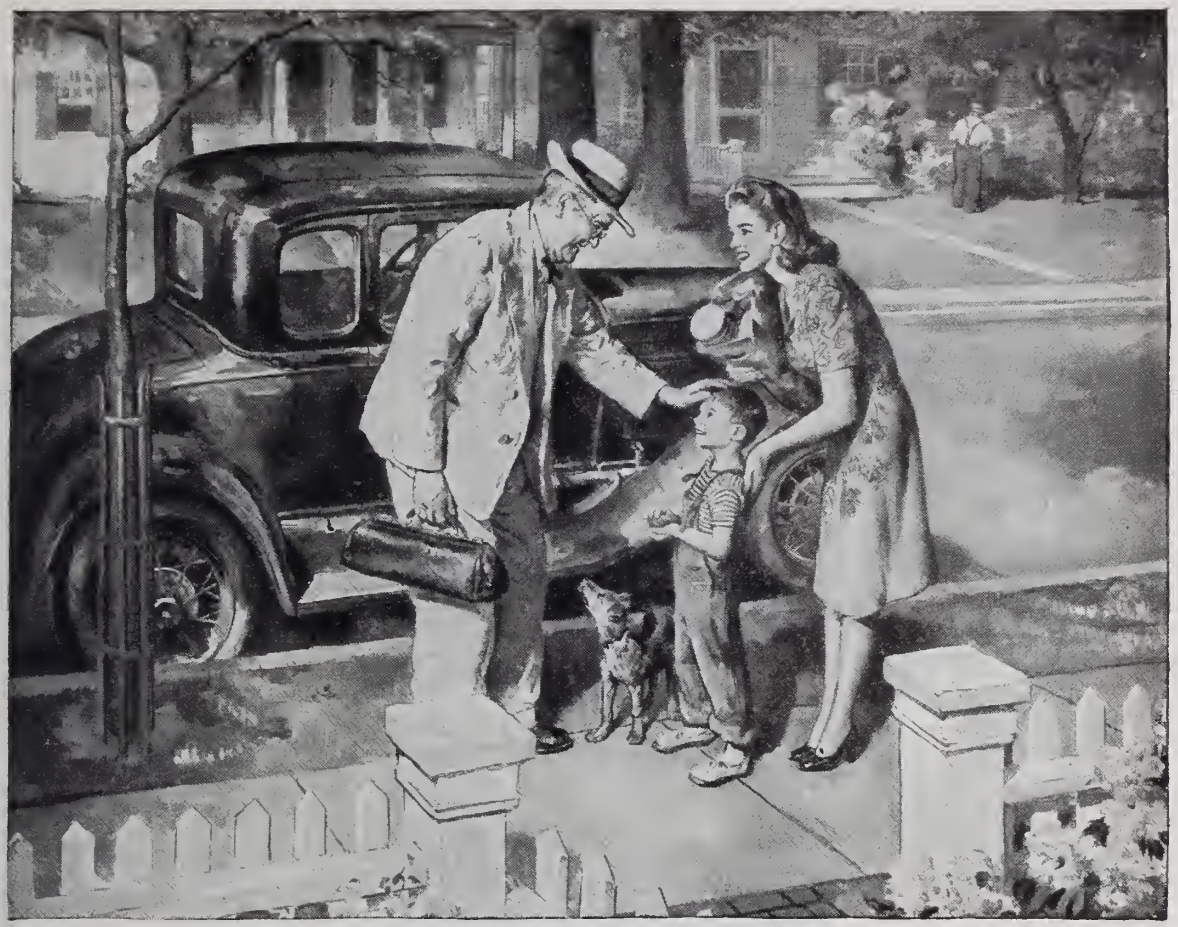
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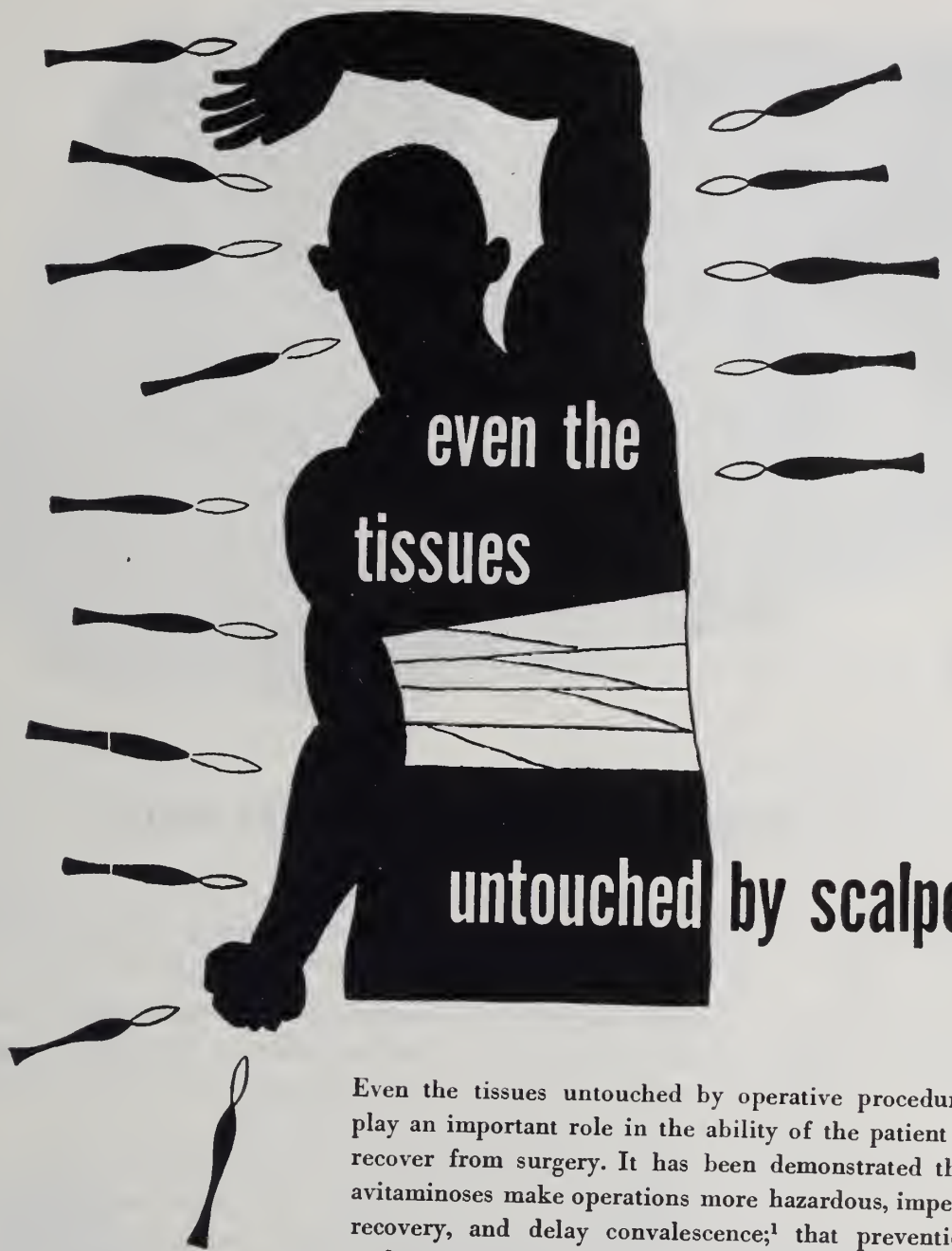
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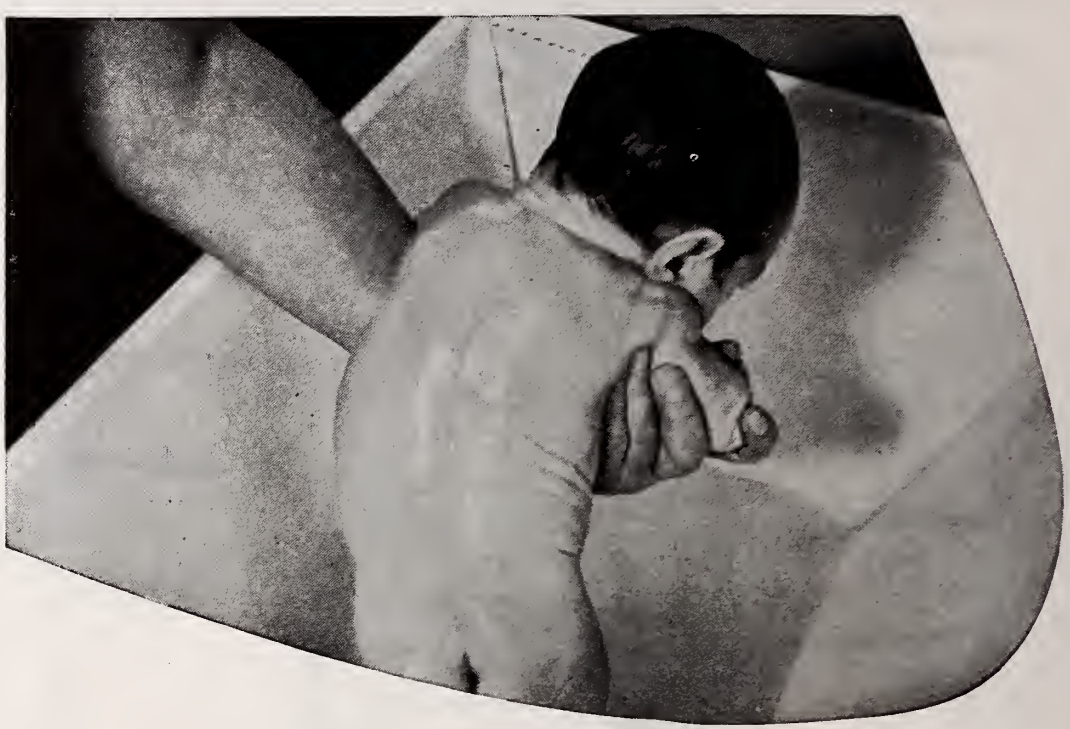
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1. Virginia M. Monthly, **72**:240 (June) 1945.
2. Am. J. Surg. **54**:299 (April) 1942.

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CARBOHYDRATE	64.8 Gm.	NIACIN	6.81 mg.
CALCIUM	1.12 Gm.	VITAMIN C	39.6 mg.
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IRON	12.0 mg.	COPPER	0.50 mg

*Based on average reported values for milk.

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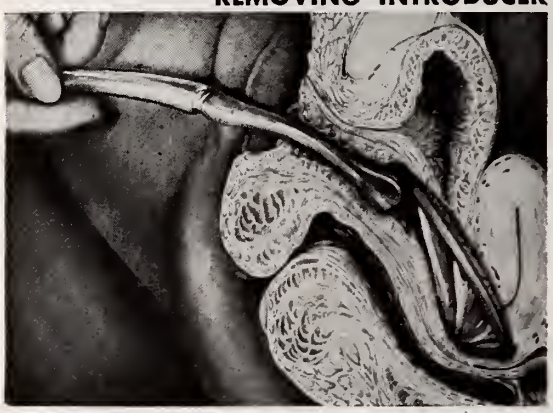


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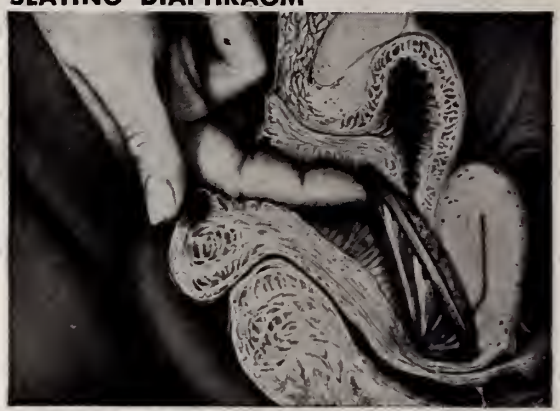


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Feinberg, S. M.: Allergy in Practice,
Chicago, The Year Book Publishers, Inc., 1944, p. 502.

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THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Published Monthly Since September, 1904

Whole Number of Issues, 505

Under the
Direction of the
Committee on Publication

Henry C. Barkhorn, M.D., Chairman

Henry A. Davidson, M.D., Editor

Place of Publication, Printing and Mailing—12 South Day Street, Orange, N. J.
Editorial and Executive Offices of the Society—315 West State Street, Trenton 8, N. J.; Tel 5776
Send all communications to the Trenton Office
Each member of the State Society is entitled to receive a copy of The Journal every month.

Vol. 43, No. 9 September, 1946 Subscriptions, $3.00 per Year
Single Copies, 30 Cents

HARRY R. NORTH, M.D., 1878—1946

A conspicuous and painful gap is left in the high command of The Medical Society of New Jersey as a result of the death of Dr. Harry R. North on August 5, 1946. For almost twenty years Dr. North carried the difficult, delicate, and not always pleasant job of piloting our Finance and Budget Committee. It was a task which required a rare combination of diplomacy, firmness, judgment, and understanding; yet, since 1927, the Society has refused to have any one but Dr. North in that important post. The present financial stability of our Society is, of course, a tribute to the skill with which he served as Finance and Budget Chairman. He labored long and labored hard in the cause of organized medicine—not only as a member of our Board of Trustees for two decades, but as treasurer of the Mercer County Medical Society for thirty years. He did this in so quiet and unassuming a manner, that we all took him and his work for granted.

In spite of his consistent and untiring efforts on behalf of organized medicine, Dr. North found time to engage in a busy private practice. He was chief of the Ear, Nose and Throat service at St. Francis Hospital, a diplomate of the American Board of Otolaryngology, and an active member of the New Jersey Surgical Society. He was born in 1878 and was graduated from the Jefferson Medical College in 1904. It was not surprising to learn that he was born in Maine. He exemplified those qualities of honesty, ruggedness, keenness and independence which we traditionally associate with the Pine Tree state. Organized medicine needs more men like Harry North.

THE PUBLIC'S OPINION OF ORGANIZED MEDICINE

The organized medical profession has never earned for itself the prestige and affection which the individual doctor enjoys. The practitioner needs no public relations program. The layman accepts the doctor of medicine as a scientist, a humanitarian, a gentleman and a scholar. Occasionally he is none of these things, but until he proves himself otherwise, the public looks on a doctor with esteem, affection and sometimes even with veneration.

The organized profession, however, enjoys no such universal public acclaim. The layman recognizes that the medical society has three functions: first, to study and disseminate scientific knowledge; second, to protect the community against quackery; third, to protect the welfare of its own members. We still have blue-ribbon rating with reference to the first two functions. Even the severest critics of organized medicine agree on the efficiency of a medical society as a scientific sounding board and its honesty and usefulness as a warrior against charlatanism. But when the layman thinks of a medical society as an organization of doctors for their mutual protection, the criticism begins, and it is at this point that our public relations standing goes into a tail-spin.

Of course we have a simple answer. We say that whatever is in the interest of the physician is in the interest of public health; if we guard the rights and privileges of doctors, we automatically guard public health. That's what we say. The layman does not believe it. He sees the doctor as a small businessman, assembling in his society, with other owners of small businesses. When retail merchants get together to form a league, the buyer begins to get worried. He assumes that whatever the purposes of such an organization, the protection of the buyer is not likely to be number one. We know that this analogy is all wrong, but we don't quite know what to do about it. Somewhere on the road between Dr. X as family practitioner and Dr. X as a representative of the medical society, that aura of confidence and esteem has been sidetracked.

Public criticism of organized medicine falls into two somewhat exclusive categories. There are those who think we are a sort of labor union; and on the other hand, those who think that organized medicine is a "big trust". Actually, organized medicine comes closer to the old idea of a guild than to the newer concepts of either labor union or monopolistic trust.

Any layman can see that a surgeon would be incapable of doing a poor appendectomy for $100 and a good one for $200. Even our severest critics know that an *individual* practitioner, when he is once on the job, will do the best he can. But the layman has not learned to extend that to doctors in the aggregate. Every doctor in the country has his quota of trusting patients, yet when you multiply the typical M.D. by a hundred thousand, and call him A.M.A. he suddenly becomes a trust or a labor union. Perhaps the entire public relations question of organized medicine can be reduced to that one problem. How can we show the public that the medical society is simply the plurality of the family doctors of America?

THE VANISHING NURSE

We don't miss the water till the well runs dry. The doctors of America have suddenly been jolted into some realization of the importance of the trained nurse in the care of patients. Here and there throughout this state—and indeed throughout every state—a hospital closes a ward or even an entire wing because of shortage of nurses. Training schools which once rejected more applicants than they accepted are now wondering where their next pupil nurse is coming from. Somehow the Lady with the Lamp is not as appealing a figure to the young girl as she was a decade ago. A doctor who needs a private duty nurse for a very sick patient counts himself lucky if he can share one on a group-nursing program. All of which makes one ask, what happened to all the nurses?

Blame for the shortage has been placed on all sorts of factors from Cupid to cupidity. It has been alleged that the Army and Navy are hoarding a large pool of nurses, that factories are outbidding hospitals for their services, that too many nurses have suddenly decided to marry and nurse their own children, that the Veterans Administration has recruited nurses without regard to civilian personnel shortage, or that too many overworked private practitioners have decided to lighten their loads by employing nurses in their offices. Probably all these factors play some role. The simplest, if least romantic explanation, however, seems to lie in the fact that hospitals underpay and overwork their nurses. A comparison of the wage-and-hour scale for a hospital floor nurse and a Veterans Administration general duty nurse, for instance, suggests that a girl has to have excessive affection for the old school tie to prefer working 48 hours a week on a surgical floor of her alma mater for a lower salary than she could command in a civil-service post at 40 hours a week. And in too many hospitals the nurse is expected to be a tray-carrier, a linen counter, a visitor-chaser, and a bed pan caddy—activities which do not seem appropriate to a highly skilled, professionally classified calling. At any rate, it is obvious that such activities now have little appeal to the high school set, and unless the profession—and it *is* a profession—is made more attractive, nurses' training schools will suffer rapidly diminishing pupil rosters.

In the Navy and Army, nurses learned that most of the housekeeping and unskilled manual work could be done by relatively untrained attendants. That's the way they will want it in civilian hospitals. And the demand seems to be a perfectly reasonable one. To put this into effect will require a larger corps of nurses' aides, orderlies, ward-maids and attendants—but it can be done. That kind of reform plus the adjustment of the salary scale to bring it into line with what professional people have a right to expect, should go far towards alleviating the shortage. Physicians have found that a concern with the material rewards of their profession need not be incompatible with the ideals and ethics of medicine; and this is as true of the disciples of Florence Nightingale as of the followers of Aesculapius.

ORIGINAL ARTICLES

THE CANCER PROGRAM IN NEW JERSEY

PART I. DIAGNOSTIC AND THERAPEUTIC CANCER CLINICS

Prepared by the Advisory Committee on Cancer Control,*
The Medical Society of New Jersey

During the last decade much interest has been manifested among physicians in the establishment of diagnostic and therapeutic cancer clinics in connection with general hospitals.

When well organized and adequately staffed, these clinics are enthusiastically received by the local medical profession. They represent our most effective means of combating cancer by bringing into close cooperation the general practitioner, the surgeon, the radiologist and the pathologist.

THE GENERAL PRACTITIONER'S ROLE

Among the medical men interested in cancer, the general practitioner is the most important. He sees the cancer patient first and usually last. He represents our first line of offense. He, above all others, must be made cancer conscious. Invariably, it follows that the close cooperation between the clinic personnel and the practitioner leads to the success of the clinic. By making the general practitioner take an active part in the diagnosis, treatment and follow-up of the case, better cooperation is obtained from the patient with resultant improvement in end results.

IMPORTANCE OF LOCAL CANCER CLINICS

Patients can be treated at decentralized cancer institutes more promptly, more efficiently and less expensively than would be the case if they were required to travel long distances. Modern treatment of cancer usually requires a prolonged, well planned course of treatment. In many cases, this period of active therapy may extend over six weeks. One should consider the economic loss if a patient had to travel fifty miles a day for a treatment lasting ten minutes. If this patient were institutionalized, the daily maintenance cost would far exceed his treatment cost. In most instances, when treatment facilities are in close proximity, the patient is ambulatory and can follow, at least to some extent, his usual line of work, thereby avoiding a total economic loss to his family. Hospitalization could then be reserved for specialized treatments. This disposes of the usual criticism from the hospital staff that the establishment of a local cancer clinic would fill otherwise active beds with chronic invalids. The reverse would be true, for by the earlier diagnosis and proper treatment more cancer patients will be cured, thus leaving fewer to occupy terminal beds.

ORGANIZATION AND OPERATION OF TUMOR CLINICS

Many inquiries have been received concerning the expense, equipment, organization and operation of tumor clinics. This report will therefore focus on the answers to these questions.

We have in mind three distinct types of tumor clinics:

A. The first is a clinic which functions six days a week under constant supervision of a trained oncologist. It treats cancer in all its phases and is organized to offer services to the public. This would, of course, require a hospital set-up which would make possible the examination of private and clinic patients. It would require integrated service in this specialty in the hospital.

B. The second type is a tumor clinic where the interested physicians on the existing staff

* Dr. William O. Wuester, Chairman
Dr. Otto R. Holters, Vice-Chairman
Dr. Emil Frankel, Consultant
Dr. Joseph I. Echikson
Dr. H. Wesley Jack
Dr. Joseph H. Kler
Dr. Thomas B. Lee
Dr. W. James Marquis
Dr. Leonid S. Snegireff

play the largest part in the work. It would call for a consultant whose function would be to aid in the organization of the clinic and development of its services. This plan presupposes very active interest on the part of a surgeon, radiologist and pathologist at the hospital who are willing to devote considerable time to such a department.

C. The third type (which may eventually develop into a full grown and well organized complete clinic) is the diagnostic or screening clinic. This could be a department in the regular out-patient clinic of the hospital. It might well be that all tumor clinics should start in this manner so that the staff might find out whether there is enough interest to warrant expenditures for a tumor clinic.

In many hospitals it will be impossible (and not advisable) to start cancer clinics of the type which have been described under the A and B headings. In every hospital, however, there are several physicians interested in malignant disease. It might be possible under these circumstances to begin what is known today as a "diagnostic cancer clinic" to which patients suspected of having cancer may be referred (either directly or indirectly, as may be seen fit) for a complete physical examination including the necessary laboratory work. This could be arranged on a part time basis in which physicians receive a portion of the fees so collected. The function of such a clinic is primarily diagnostic. Once diagnosis is made the patient is referred back to the family physician.

Arrangements should be made with certain institutions for the referral of specific cases from diagnostic clinics, when such referrals are necessary and agreeable to the family physician.

The set-up of a diagnostic clinic has to be individualized to meet the needs of a hospital.

COOPERATION OF MEDICAL ORGANIZATIONS OFFERED

A recent survey has brought out the fact that although many cancer clinics in this state are well organized and are functioning admirably, many others exist only as paper organizations.

The committee should like to see these clinics improved and attain a status comparable to the average well functioning clinic serving the community and reflecting credit on the local profession. Towards this end the Cancer Control Committee of The Medical Society of New Jersey and the American Cancer Society are prepared to render technical and financial aid to hospitals desiring the establishment of cancer clinics meeting the standards set forth above.

Inquiries should be addressed to:

Cancer Control Committee of The Medical Society of New Jersey
315 West State Street, Trenton 8, N. J.
or
Medical Director
American Cancer Society
790 Broad Street, Newark 2, N. J.

STAFF ORGANIZATION

1. *Active personnel* may consist of ten persons as follows: (1) The Executive Director, who would be the attending surgeon, Department of Malignant and Allied Diseases; (2) an associate attending surgeon; (3) an associate radiologist; (4) an assistant attending surgeon; (5) an intern; (6) the pathologist; (7) (8) two dispensary physicians. To permit as many physicians as possible to have contact with this work, the dispensary physicians should be rotated. (9) (10) Nurse and secretary.

2. *Consulting personnel* should consist of an attending on duty from each of the following departments: (1) surgery, (2) internal medicine, (3) urology, (4) otolaryngology, (5) gynecology, (6) orthopedics, (7) dermatology, (8) neurology, (9) obstetrics and (10) dentistry.

Of necessity this table of organization will not be universally applicable, but it suggests a nucleus around which changes may be made to suit individual needs.

If a part-time oncologist is used, it will be found that after several years, the attending staff personnel who have had sufficient time and interest will have acquired considerable knowledge and skill in the management of malignant disease. They, therefore, may assume progressively more authority and more responsibility, until the time is reached when it is no longer necessary for the consulting on-

cologist to spend as much time in the clinic. It is essential, however, that the interest in the clinic be continually stimulated so that the department is always modern in its concepts.

SUGGESTED RULES AND REGULATIONS

Following are some of the rules and regulations applicable to cancer clinics:

1. No indigent patient should be admitted directly unless referred from a recognized cancer clinic.

2. Private patients should be admitted directly to the clinic, or to physician designated, upon written request of the family physician.

3. Physicians referring indigent patients refer them to the dispensary first; and the dispensary physician in the appropriate departments refers the case to the cancer clinic. This rule may be altered to suit variable circumstances.

4. For all private patients, and so far as is possible in the case of clinic patients, a written report should be made to the family physician. The report includes diagnosis and recommendations for management of the disease.

5. No treatment on private patients is undertaken without notification to the family physician.

6a. A consultation request should be sent to the cancer clinic on all general service patients suspected of having a malignant disease. It remains at the discretion of the attending on service whether the patient is referred to the department of malignant and allied diseases after an opinion is rendered. If surgery is required, the cancer service should have the privilege of assisting.

6b. On all general service patients admitted to the cancer service, a consultation should be required with the interested service; and in the event of surgery, the department in which that particular type of service falls should have the privilege of assisting. (This is extremely important and requires close cooperation on the part of the staff. It will also improve the quality of cancer work in the hospitals.)

Rules governing the admission of general service patients into the hospital would depend upon whether there was a recognized cancer service in the hospital wards.

COST OF ESTABLISHING TUMOR CLINICS

The special tumor clinic may be established for approximately fifteen to twenty thousand dollars. Any material alterations or the building of additional housing units would, of course, increase this estimate. It is possible to establish diagnostic and treatment facilities much more cheaply than this; also much more expensively. We have chosen this estimate because we feel that it covers all the necessities for diagnosis and treatment and has proved completely satisfactory.

Generally speaking, the minimum floor space requirements will vary between 1,000 and 1,200 square feet. The use of two or more examining rooms is especially recommended for busy clinics. The availability of space determines the planning of the rooms.

ROENTGEN EQUIPMENT

Largest single expense is the 200 to 250 kilovolt x-ray machine and the 100 kilovolt machine, for which, in the aggregate, $8600 to $10,000 is allowed. If it appears essential to do so, considerable saving may be effected by not installing a separate transmitter for the low voltage machine. It then becomes necessary to use a high tension switch in conjunction with the transformers for the high voltage machine. Objections may be raised against this practice because only one machine may be run at any one time. However when one considers the small number of low voltage treatments in comparison with the larger number of high voltage treatments and the space saved by the use of only one treatment room and control panel for all roentgen therapy, the advantages far outweigh the disadvantages, if the latter exist at all.

Supplementary equipment for the x-ray machines is as follows (some of the costs are omitted because they vary considerably):

Schreiner adjustable diaphragm ..... $ 150
(With this diaphragm one is able to obtain practically any desired size square or rectangular portal without the use of special cylinders for each.)

Circular cylinders (cones)—For circular portals. Sizes 10, 9, 8, 7, 6, 5, 4, 3.5, 2.5 centimeters.

Master cylinder for therapy at 50 centimeters T.S.D.

Master cylinder for therapy at 70 centimeters T.S.D.

Intraoral cylinders—Sizes 4, 3.5, 3 centimeters. Used for selected intraoral therapy.

One 14 x 7 cm. rectangular cylinder for esophageal or other specialized treatment at 70 centimeters.

Metal pointers used to center the x-ray beam at the desired area. Since low voltage is operated at 30 and 20 cm. T.S.D. these cylinders are interchangeable on both machines. This avoids the purchase of separate cylinders for the low voltage machine, thereby affording a considerable saving.

Complete lead lining for therapy room equivalent to the Bureau of Standards recommendations of 5/32 in. 1,500
(This estimate varies according to the amount and type of lead or lead panelling used.)

Because the modern technic of roentgen therapy for cancer is becoming more exact, we do not believe any economy should be effected by restriction of the accessories mentioned above.

RADIUM

Radium may be purchased at approximately $21.50 per milligramme in amounts of 100 milligrammes; or rented for $40 per month, the latter covering all insurance (2 per cent of value per gramme) and all necessary instruments within certain limitations.

The following is the radium outline suitable for a complete clinic:

Radium—150 to 250 milligrammes—put up in 30 to 50 platinum cells of 11.5 mm length, 12 mm wall thickness, 1 mm external diameter, containing 5 mg. radium	$3,360.00 to $5,600.00
12 special platinum iridium sheath needles, single eyelet, removable point (Treves needle) 17 mm in length, 1.65 external diameter and 3 mm wall thickness	144.00
12 special gold sheath needles with removable platinum iridium trocar points with double eyelets, each for 2 cell overall length wall thickness 0.3 mm.	105.00
8 special gold sheath needles as above but holding 4 cells, overall length	90.00
6 standard platinum capsules of 0.8 mm wall thickness each to contain 5 single cells	210.00
1 special platinum capsule of 0.8 mm wall thickness to hold 8 single cells	40.00
3 brass plaques of various sizes (square, long, round) to hold radium for superficial application	15.00
1 needle extractor	2.75
1 instrument for inserting needles (straight)	2.75
1 needle inserting forceps (retro and extra groove made for straight insertion)	5.00
1 needle inserting forceps (straight and right angle grooves)	5.00
1 long forceps (for handling cells)	2.50
1 rubber tubing	1.00
1 special intubating forcep	7.00
2 special chuck device for opening platinum capsules and sheath needles	10.00
1 special double and point remover (12 inches long)	2.00
1 Healy two-way cervical applicator	18.00
1 lead storage chest	150.00
1 Failla type carrying case	60.00
1 lead radium shield	150.00
1 combination safe for storage of radium	50.00

Since accurate diagnosis is so important in cancer therapy, proper equipment incident to this is necessary. Instruments listed below may already be available in the hospital, in which case it is usually not necessary to duplicate them, although having the clinic equipped in its own right is more advantageous.

GENERAL EQUIPMENT

The following is a list of diagnostic and therapeutic instruments suggested as a full compliment:

1 treatment chair with headrest	$ 16.00
1 fountain cuspidor (on pedestal) complete with saliva ejector and drinking attachment	71.00
1 nose and throat outfit with large heavy duty pump instead of small pump (several attachments purposely omitted)	350.00
1 bronchoscope sterilizer (25 in.)	
1 small sterilizer (10½ in.)	
1 oesophagoscope medium (Janeway or Jackson type)	45.00
1 gastroscope (Janeway type)	50.00
1 set United dilating olives	35.00
1 Jackson laryngoscope	17.50
1 Jackson laryngoscope (anterior commisure)	20.00
1 Jackson bronchoscope 204 7 x 40	13.50
1 Jackson bronchoscope 9 x 40	13.50
12 bulbs for laryngoscope and bronchoscope	12.00
1 Clerf's atomizer	8.25
1 Yankauer glass dropper	1.50
2 Jackson cotton carriers	8.25
1 head lamp	15.00
1 Martin superficial tongue and throat biopsy forceps	7.50
1 Martin thin blade throat scissors	5.50
1 Martin universal handle for biopsy tips	12.50
1 Martin round biopsy tip for above	12.50
1 Martin angulated tip for above	12.50
1 canula for above—8" straight	4.50
1 canula, 12" straight	5.50
1 canula, 16" straight	6.00
1 canula, 22" straight	7.00

1 canula, curved laryngeal	4.50
1 biopsy forceps for post nasal work	27.50
2 bayonet dressing forceps	4.00
1 soft palate retractor	15.00
2 tongue depressors (metal)	4.00
6 assorted mirrors	5.40
1 Baucheron ear speculum set	2.25
1 ring ear curette	1.50
1 Martin cheek retractor	5.50
1 Jenning's mouth gag	10.50
2 nasal speculas	5.50
8 tracheal tubes with obturators, Nos. 4, 5, 6 x 3, 7, 8, 9	50.00
2 operating and examining tables	160.00
1 Mayo stand	17.50
1 instrument and supply cabinet	120.00
2 current controllers for diagnostic instruments	17.00
2 aspirating biopsy syringes	15.00
4 aspiration biopsy needles—2"	5.60
4 aspiration biopsy needles—3"	5.60
2 aspiration biopsy needles—5"	3.30
1 aspiration biopsy needle —9"	3.50
1 Labot type regional syringe	5.00
3 Bard-Parker handles No. 3	3.00
1 cautery for A. C. current complete with pistol grip handle, illumination light and assortment of cautery tips	35.00
12 mosquito forceps (B. L.)	60.00
6 Kelly forceps (B. L.)	30.00
2 plastic retractors	4.00
4 assorted plastic scissors	16.00
2 fixation plastic forceps, without catch	6.50
1 Haydeman bone ronguer	12.00
1 mastoid retractor	12.50
2 needle holders	10.00
4 dressing forceps	10.60
3 tissue forceps	6.75
2 sponge forceps—long	6.50
3 M. O. scissors 5½ inches straight	9.75
1 curved Mayo scissor 5½ inch	6.50
1 bone curette No. 5	3.00
1 bandage scissor 7½ inch	2.25
1 Bowles stethoscope	2.50
3 stainless steel pus basins 10 inch	7.50
1 mercurial sphygmomanometer	27.50
2—2 cc syringes	2.50
1—5 cc syringe	2.00
1—10 cc syringe	2.50
1—20 cc syringe	3.00
3 dozen assorted needles	8.50
1 small spot lamp	18.50
1 endotherm machine (complete)	300.00
1 scale	30.00
2 waste receptacles	5.00
Furniture	600.00
Photographic equipment	75.00
1 cystoscopic biopsy forceps	18.00
1 cystoscope with convex sheath	160.00
1 A. C. M1 battery box unit	18.50
1 wall irrigating outfit	18.50
1 proctoscope—complete set	41.50
1 special proctoscope suction tube	3.70
1 Healy cervical biopsy forcep	10.50
1 uterine forceps	3.25
3 Graves speculum (large, medium, small)	11.50
1 plain uterine sound	1.25
1 uterine tenaculum forceps	3.75
1 Goudel uterine dilator	12.65
1 uterine irrigating sound	1.75

This is the first in a series of articles on the cancer program in New Jersey.

VITAMIN B AND MURINE TYPHUS

Para-amino-benzoic acid, which belongs to the vitamin B complex, was effective in arresting 29 cases of murine typhus, according to a paper by Pauk K. Smith published in an August issue of *J. A. M. A.* Twenty-nine patients with murine typhus received 2 grams of para-amino-benzoic acid every two hours until their temperatures returned to normal. Another group of 29 patients not given the drug were observed for comparison.

The author states that "on the whole the patients treated with para-amino-benzoic acid did better than those not treated. Of those not treated, 22 of 29 had a fever for 12 or more days, whereas in the treated group only seven of 29 had a fever for so long. Although the means of the duration of fever in the two groups (10.3 and 13.2 days respectively) are not widely different, it has been shown statistically that the probability of the difference occurring by chance is less than one in 100."

Murine typhus is so called because it is primarily a disease of rats. It is transferred from rat to man and from rat to rat by the rat flea. It occurs most frequently in the late summer or autumn.

"No attempt was made to select the patients for this study," the author states. "The proposed study was presented to the Bexar County (Texas) Medical Society and the physicians in this area were requested to refer patients for treatment as soon as, in their opinion, there was a probability of endemic (murine) typhus. The patients were at all times under the direct supervision of the physicians to whom they reported for treatment."

DIABETES IN CHILDREN *

Selma Weiss, M.D., Newark

Before insulin, diabetes was considered a fatal disease in children. In the Nauyn era, 1898 to 1914, the life expectancy of a child was short, a few months or even weeks. In the Allen era, 1914 to 1922, it was between one and two years. Now the diabetic child may look forward to practically a full span.

Diabetes frequently occurs during childhood. Errors in diagnosis may be made as not infrequently children spill sugar in the urine. Diagnosis of diabetes mellitus should not be made unless there is hyperglycemia. It is sometimes necessary to do a glucose tolerance test to make a diagnosis. About 10 per cent of diabetics develop the disease early in childhood. According to the National Health Survey, the incidence is one in 2500 children. Before the age of ten, the sex ratio is about even. It manifests itself about two years earlier in girls than in boys, probably because of their earlier gonadal development.

While the underlying causes of diabetes mellitus are not clearly understood, heredity appears to be an important factor. According to White, 20 per cent of the children have a known diabetic relative, but after following the disease for 15 years, 50 per cent have a known heredity. Another factor seems to be the interrelationship of the endocrine glands, especially the pituitary; although the pancreatic origin of the disease is again being considered.

Onset of diabetes in a child is, as a rule, much more acute and severe than in the adult. Often a diagnosis is not made until the child is in coma. The symptoms are: loss of weight and strength, polydypsia, polyuria, listlessness, irritability, excessive hunger or sometimes loss of appetite, dryness of the mouth and often vague pains, especially in the limbs.

Treatment consists of (1) education of patient and family, (2) diet, (3) insulin and (4) exercise.

EDUCATION

Whenever possible, the patient should be hospitalized for 7 to 10 days for adjustment and education. After discharge from the hospital, the child should report to the office at intervals for observation and control. He should bring records of daily urine tests for sugar, the diet and insulin lists. Frequency of visits depends on the child's condition. Blood sugar determinations should be done from time to time to see that the fasting blood sugar is neither too high nor too low. Since diabetes is a life-long disease, treatment and management should be adjusted so as not to interfere with physical and mental development. The regimen should, at the outset, promote a life of comfort and usefulness and not interfere with the child's normal activities. If the child fails to accept his disease because he cannot live as other children do, he will be handicapped not only during childhood, but the rest of his life.

Parents should be taught the nature of the illness and what rôle they must assume in treating the child. They should be taught how to test the urine for sugar and acetone. Yet the parent must not become over-protective and interfere with the child's social adjustment. Companions and teachers should be familiarized with the symptoms of insulin reactions and what to do when they occur.

DIET

The dietary treatment of the diabetic child differs from that of the adult in whom best results are obtained from undernutrition. In children, caloric requirement must be adequate for normal growth and development. It does not differ from that of the non-diabetic child. While undernutrition is to be avoided in children, care should be taken to prevent obesity. Mineral and vitamin content of the diet must be adequate. This is provided by including in

* Presented at Academy of Medicine of Northern New Jersey, Oct. 26, 1944.

the daily diet one quart of milk, butter, eggs, cheese, fresh fruits and vegetables. To insure optimum intake, vitamins, especially A and D, may be added. Special diabetic foods are not necessary. The amount of carbohydrates given varies with different clinicians. Our group at the Newark City Hospital has been using a moderately high carbohydrate diet. In children under five, we give from 90 to 125 Gms. per day. In older children we give from 125 to 200 Gms. per day. The protein must be adequate for normal growth and development; 3 Gms. per Kg. body weight in very young children and from 2.5 to 1.5 Gms. per Kg. body weight in older children. The amount of F should be sufficient to make up the daily caloric requirement of the child.

The division of carbohydrate during the day depends on the kind of insulin used and on the number of daily injections. It is difficult to give set rules as adjustments must be made to fit the individual case. General procedure is as follows: when regular insulin is given before breakfast only, the carbohydrates are divided between the three meals thus: about 2/5 of the total for breakfast, of which 10 Gms. are a mid-morning snack, and the rest evenly divided between lunch and supper. When two doses of insulin are given, one before breakfast and the other before supper, 10 Gms. are deducted from the evening meal and given two hours later. These after-meal snacks are, of course, given to ward off insulin reactions. When protamin zinc insulin is used, because of its slow and prolonged action, the carbohydrates are divided as follows: 1/5 for breakfast, 2/5 for lunch and 2/5 for supper with at least a total of 20 Gms. deducted from the lunch and evening meals and given at bedtime. If R and Pr. Zn. I are given before breakfast, then the mid-morning meal should also be given, making a total of five feedings, three large meals and two snacks, one two hours after breakfast and one at bedtime. Combinations of protamin zinc and insulin may also be used in suitable cases. When globin insulin is used, the carbohydrates are divided as follows: about 1/5 or less for breakfast, 3/5 at noon, from which 10-15 Gms. are deducted for a mid-afternoon snack and the rest of the carbohydrates for supper.

INSULIN

Insulin should be administered to children as soon as a diagnosis is made. As a rule, they require both the regular and protamin zinc for optimum control. With these two types of insulin, it is generally possible to maintain a fair degree of control even in the severest diabetic.

Dose varies with the age of the child and the severity of the disease. The dose must be large enough to prevent any considerable spill of sugar in the urine following the meal after which it is given, and yet prevent a reaction before the next meal. The dose of Pn. Zn. I. must be large enough to prevent any considerable spill of sugar in the early morning urine, keep the fasting blood sugar within reasonable limits and prevent reactions in the early morning hours. Because of the constant growth of the child, the dose of insulin has to be readjusted continuously, and has to be changed during any acute infection or illness.

The child may be considered "standardized" when his urine is free from ketone bodies, when his total excretion of sugar in the urine is small in comparison with his carbohydrate intake, when the blood sugar fluctuation is within reasonable limits during the entire day, and when he is free from reactions (except when such reactions are caused by unusual overactivity or by a gastric upset). Maintenance of normal weight for age and height is also evidence of good control.

EXERCISE

Exercise is an important adjunct to the treatment of diabetes mellitus. It is advisable to prescribe exercise *after* meals, when the blood sugar rises, rather than before meals, when the blood sugar falls.

COMPLICATIONS

The complications of diabetes in childhood may be summarized briefly as follows: coma, heptomegaly, infections, skin lesions, and sometimes failure of growth. The latter can now, as a rule, be corrected with the proper endocrine medication.

Coma is frequently the result of dietary indiscretions, omission of insulin or occurrence of an acute infection. Treatment of coma consists of (1) insulin to combat diabetes, (2) fluids to combat dehydration and (3) gastric lavage and enemas to combat gastro-intestinal stasis. The dose of the insulin and the frequency of administration depend upon the age of the child, the clinical severity of the case and on the laboratory findings: that is, the blood sugar, the amount of sugar and ketones in the urine, and when possible to obtain, upon the carbon dioxid combing power of the plasma. We use regular insulin in combating acidosis. Dose may vary from 10 units every hour in a very young child, to 30 to 40 units every half hour in an adolescent.

To combat dehydration we use 5 per cent glucose in normal saline given intravenously or subcutaneously, the amount varying from 1000 to 3000 c.c., in 24 hours. Dilatation of the stomach is frequent in coma. The stomach, as a rule, is filled with fluid, undigested food, and old blood. Removal of these contents with warm tap water relieves the abdominal distress and stops the nausea and vomiting. Stimulants are seldom necessary and, as a rule, the prognosis is good.

CONCLUSION

Within the past two decades, great strides have been made in our knowledge and treatment of diabetes mellitus. As a result, diabetes mellitus is no longer a fatal disease in children. In fact, it is now possible for the diabetic child to develop normally both physically and socially.

2 Stratford Place

THE Rh FACTOR AND THE PUBLIC HEALTH LABORATORY *

FREDERICK P. LEE, M.D.; ANNA I. VAN SAUN and EVELYN L. BROWN, B.A.
Paterson, N. J.

Our entrance into this somewhat unusual field was due to a request from the Maternal Welfare Committee of the Passaic County Medical Society. One of our largest hospitals was not ready to take on the added burden of Rh determinations for its blood bank and it was suggested that we do this work for them. It was also suggested that, since we received a very large number of specimens for premarital and antepartum Wassermann tests, we should perform Rh determinations on these specimens. Accordingly, after a preliminary period of study we began this work as a routine in June, 1944.

Nearly 3,000 blood specimens have been tested, the great majority of them ante partum.

Approximately 15 per cent of the specimens received from antepartum sources were Rh negative. All Rh negative specimens were retested with at least three different serums secured from different sources, and those giving anomalous results were checked by Dr. Philip Levine in his laboratories at Linden, N. J.

We also request a specimen of blood from the husband of each Rh negative woman. The obstetrician secures this for us. Thus far each husband has been coöperative with the exception of two, who could not see that they had anything to do with it! Of 98 husbands tested, 80 were Rh positive and 14 were Rh negative. The husbands of four Rh positive women were Rh negative.

Of 749 specimens which have been tested for the hospital blood bank 14 per cent were Rh negative, thus forming a nucleus for the hospital's Rh negative donor's club.

Seven cases of erythroblastosis have come to our attention through this work. All of the mothers were Rh negative with one exception. All of the fathers were Rh positive. All the babies were Rh positive. The one exception to the Rh negative mothers could not be explained. Father, mother and baby were Rh positive, though the infant was definitely erythroblastotic. Three of the babies lived, as the result of appropriate treatment with transfusions of Rh negative blood. The child of the Rh positive parents died.—J. A. M. A., Vol. 128, No. 1.

* Abstrated from *The Journal of the American Medical Association.*

NEWER KNOWLEDGE OF MALARIA *

By J. B. RICE, M.D., New York City

Malaria is the most widespread serious ailment of man. As Manson has said: "Malaria causes more deaths and more predisposition to death than all the other parasites together."

Malaria is not merely a tropical disease; it is truly cosmopolitan—occurring in all the continents of the globe and in most of the islands, impairing the health of a quarter of all human beings. It has actually been known to invade the subarctics. In the past, the disease was not unknown as far north as Leningrad, and in the latter half of the 17th century, several severe epidemics ravaged New England.

In thwarting human progress, no organism has ever remotely approached the evil record of the malaria parasite. It has held the earth's greatest continent, Asia, in a state of semi-civilization and the second greatest, Africa, in savagery. The social, economic and cultural progress of South and Central America and Southern Europe has been seriously handicapped. Malaria has played a more important role in the development of mankind than any other disease. Historians attribute, to a large extent, the decay and fall of the Greek and Roman civilizations to the debilitating effects of malaria on the physical and moral fiber of the populations. Malaria has even exercised a dominant influence on the outcome of wars, being largely responsible for stopping Genghis Khan in western Europe, Napoleon in Egypt, the British in Gallipoli and the Germans in Salonika. That it was not a factor in deciding the outcome in World War II is ascribed to the use of two synthetic chemicals, atabrine (quinacrine) and D.D.T.

Biologically speaking, this tiny and delicate parasite is one of the most successful of living things despite its absolute dependence for continued existence on the whim of a fragile insect, the anopheles mosquito. This organism can not move from patient to patient under its own power; in disseminating itself so widely, its efficiency is due largely to the fact that it wisely depends upon the reproductive instinct of the female mosquito. The female anopheles copulates but once. After that, for the remainder of her life, her entire sex potential is devoted to the production of eggs. Although she can live beautifully on a diet of plant juices, she must have a blood meal before she is capable of maturing each batch of eggs.

Under ordinary circumstances the female anopheles bites frequently, that is every three or four days. She is therefore admirably suited to extract the parasite from one host and, after it has undergone its cycle of development in her body, to transfer it to another. The fact that the parasite does no harm whatever to the infected mosquito is further evidence of the remarkable biologic success achieved by this lowly parasite. Unfortunately, however, the malaria organism is not so benevolent to its human host.

QUININE

The struggle between the human race and the malaria parasite has gone on for thousands of years; and up to 300 years ago the victories were all with the parasite. In 1638 the Countess of Cinchon was cured of malaria by the noted physician De La Vega, who gave her a concoction of Peruvian bark which he had obtained from the Indians of Peru. This was man's first victory over the malaria parasite. Cinchona and its alkaloid quinine provided him with a powerful weapon with which to fight back. Two and a half centuries were to pass before the next victory was won. In 1880, Laveran, a French military surgeon in Algeria, discovered the microscopic cause of the disease. This brought the enemy out into the open; for the first time men could see what they were fighting. Twenty years later, Manson and Ross showed that anopheles mosquitoes were responsible for carrying malaria from one patient to another. With 350 species of anopheles in the world, at least 90 of which are known to be capable of transmitting malaria, men at last knew the magnitude of the problem that faced them.

* Read by invitation at the Annual Meeting, Academy of Medicine of Northern New Jersey, May 16, 1946.

PLASMOCHIN AND ATABRINE

The discovery of the action of the synthetic drug, plasmochin, by Roehl in 1926 brought the chemists into the struggle and led directly to the discovery of atabrine by Kikuth in 1932. The possession of atabrine and plasmochin at last enabled man to hold his own with the parasite. For atabrine cures one of the commonest forms of malaria, that due to *P. falciparum,* and promptly stops the attacks of the other forms. In small daily doses, it acts as a suppressive, preventing the development of clinical malaria in a high proportion of cases, enabling man to live, work, and fight wars in malarious regions which would otherwise be closed to him. Plasmochin kills the sexual forms of *P. falciparum* responsible for carrying the disease to mosquitoes. This drug, combined with the direct attack on the mosquito itself by filling and draining its swampy breeding places, and poisoning its larval stages with Paris Green and oil carried the war into the enemy's country. With all these weapons, however, man was able to reduce or eliminate malaria from only a few insignificant areas of the globe.

THE WAR AGAINST MALARIA

This was the situation at the beginning of World War II, when the Board for the Coordination of Malaria Studies of the National Research Council was established. This board, at an expense of $7,000,000, mobilized the scientific manpower of the country in one of the most extensive programs of cooperative research ever undertaken. As a result of this reinvestigation of the entire malaria problem, two important advances were made: new and exact knowledge regarding the natural history of the malaria parasite was obtained, and powerful new drugs were developed and tested.

Several mysteries regarding the life cycle of the parasite were cleared up. It has long been known, for example, that no amount of treatment administered during the ten to fifteen-day period between the bite of the infected mosquito and the onset of the attack of clinical malaria would prevent or even delay it. It was also known that, during this latent period, as much as a pint of blood could be withdrawn and injected into another susceptible individual without his acquiring malaria, although the patient from whom the blood had been taken developed his clinical attack on schedule. A third mystery which plagued malariologists was why no amount of treatment with either quinine or atabrine could be relied upon to cure *vivax* malaria permanently.

It is now known with considerable certainty that when the female mosquito injects the sporozoites of malaria into an individual, a cycle of development takes place in the tissue cells before the red blood cells are ever invaded; and that the duration of this tissue cycle varies with the different species of human malaria parasites. In the case of *falciparum* malaria, for example, the exoerythrocytic cycle ceases abruptly when all the parasites invade the red blood corpuscles at one time, and thus precipitate the clinical attack. Whereas with *vivax* malaria and probably with *quartan* and the rare *ovale* as well, this exoerythrocytic development does not stop with invasion of the red blood cells. In the case of *vivax* the parasite may continue to develop in the tissue cells for as long as two or three years. From time to time, showers of these tissue forms enter the blood, producing clinical relapses.

Facts regarding the exoerythrocytic cycle of bird malaria, uncovered during the past ten years, forecast the truth, but it remained for Huff and Coulston of the University of Chicago to work out the whole cycle of exoerythrocytic development of *P. gallinaceum,* a malaria parasite of chickens. Appropriately enough, they named the first generation of these parasite "cryptozoites," meaning hidden animals.

Although no one has reported seeing the cryptozoites of human malaria, there is no doubt that they exist and that an exoerythrocytic cycle of development takes place similar to that which has been demonstrated in birds. The importance of this discovery and its implications on treatment and prevention of malaria can hardly be overestimated.

Since atabrine and quinine attack only the blood parasites and have no effect on the exoerythrocytic forms, it is apparent why no amount of treatment can surely prevent relapses in *vivax* malaria; and we can understand now, why enough atabrine will cure *falciparum*

malaria permanently. The presence of the parasite in the tissue cells and its absence from the blood during the incubation period explain why the disease cannot be transmitted by blood transfusion during this interval, and also why treatment during the latent period cannot prevent the subsequent attack. Atabrine, and to a less extent quinine, when given in small daily doses can prevent the appearance of clinical malaria by holding the development of the blood parasites in check and not by an effect on the tissue parasites. Service men who have been infected may have enjoyed perfect health while taking suppressive atabrine overseas, only to suffer their first attack on return to this country, when discontinuance of treatment permits development of the blood parasites.

ARALEN (CHLOROQUINE)

Relapse in *vivax* malaria cannot be prevented with certainty until a drug is found which will reach into the tissue cells and kill the stage of the parasite developing there. This was one of the aims of the research program carried out by the National Research Council. Organic chemists of all the great pharmaceutical houses, universities and research institutions were invited to submit new compounds for study. More than 15,000 were synthesized and tested; among them many members of the acridine series of which atabrine is one, and of the quinoline series already represented by quinine and plasmochin. The most important new discovery is a member of the 4-amino-quinoline group designated SN 7618 and now named "aralen". This drug, although not an acridine compound, has an action similar to, but far more potent than, atabrine.

Chemically, aralen or SN 7618, is 7 chloro-4 (4 diethylamino-1-methylbutylamino) quinoline diphosphate.

Before it was ever given to human beings aralen was extensively tested in the avian malarias. It was found to be three times more active than atabrine and 32 times more active than quinine in *P. cathemerium* infections of canaries and ducks; thirteen times more active than atabrine and eight times more active than quinine in *P. gallinaceum* infections of chickens; and twice as active as atabrine and eight times more active than quinine in *P. lophurae* infections of ducks.

The acute and long term toxicity by various routes of administration was studied in birds, mice, rats, rabbits, dogs and monkeys. In general, it may be said that its toxicity in these animals is very close to that of atabrine. Monkeys tolerated daily oral doses of 80 milligrammes per kilogram of body weight for one month without outward manifestations of toxicity. Double this dose was, however, fatal in two weeks. Aralen seems to be less toxic for monkeys than for dogs. The latter animals suffer severe reactions on 40 milligrames per kilogram of body weight and succumbed to double that dose. Death seems to be due to cerebral irritation and impairment of vital functions.

Inasmuch as quinoline compounds have been reported to have produced deleterious effects on the pancreas of experimental animals, careful observations were made on the blood sugar and urine of rabbits receiving the drug. It was concluded that aralen had no diabetogenic effect.

Both optical isomers were prepared and compared with the racemic form in animal studies. No difference in toxicity of the three forms could be demonstrated.

Extensive studies on toxicity and antimalarial activity of aralen have been carried out on human volunteers. It has been used in the treatment of approximately 5,000 malaria patients, many of them veterans returned from all parts of the world. In a total dose of 2.5 Gm. administered over a period of three days it can be counted upon to cure *falciparum* malaria and to interrupt promptly the attacks of all forms of the disease. However, as in the case of atabrine and quinine, from two-thirds to three-fourth of *vivax* cases will relapse in from one to several months after treatment. Chances of permanent cure seem to be about the same regardless of whether the patient treated is suffering from a primary attack or a relapse. Each time a patient relapses and is treated with either aralen or atabrine, his chance of permanent cure lies between 25 and 35 per cent. With quinine, chance of permanent cure is somewhat less.

The chief advantage of the new drug over atabrine, from the therapeutic standpoint, is its greater rapidity of action. In a series of 60 patients the temperature reached normal within 24 hours of beginning treatment and did not rise again in 96 per cent of the cases, whereas with atabrine only 26 per cent were permanently fever-free in the same time. In general, atabrine requires two or three days (and rarely

longer) to interrupt a malaria attack; aralen seldom requires more than one day.

With respect to suppression of clinical attacks, a single weekly dose of 0.5 Gm. of aralen appears to be at least equal to a daily dose of 0.1 Gm. of atabrine. In another experiment 1.6 Gm. given on a single day of each month protected 90 per cent of the cases of *vivax* malaria from relapse. In field studies, a weekly suppressive dose eliminated all parasites from the blood of subjects after the third dose had been given. During this same period, in a control group receiving no treatment, the parasite index rose from 17 to 42 per cent in adults and from 50 to 92 per cent in children.

Absorption from the gastro-intestinal tract is somewhat more rapid than that of atabrine, and is almost complete. Considerable amounts of the drug are concentrated in the organs, especially the liver, spleen, kidneys and lungs. It is excreted slowly, the concentration in body fluids falling about 60 per cent per week after administration is discontinued.

In man, doses of 0.8 Gm. weekly, which are in excess of those required for adequate suppression of malaria, produced no evidence of serious toxicity when continued for eleven months. It is less likely than atabrine to produce minor side reactions such as headache, pruritis and gastro-intestinal complaints. In a few individuals, large doses have provoked transient visual symptoms, consisting primarily of a slight lengthening of accommodation time for distant objects. Aralen is not a dye and does not produce any discoloration of the skin.

SN 13276

A second drug, a member of the 8-aminoquinoline series, SN 13276, has recently been announced—a little prematurely perhaps. Chemically it is 8-[5-(isopropylamino)-pentylamino]-6-methoxy quinoline phosphate.

It is hoped that SN 13276 may cure *vivax* malaria as completely and permanently as aralen and atabrine cure *falciparum* malaria; and, indeed, its administration to a small number of cases has prevented relapses over a period of several months. Unfortunately, it is not as well tolerated as aralen, and whether it can be given with safety in adequate dosage remains for future work to determine. An experience of hundreds or thousands of cases must be accumulated before it can be decided whether SN 13276 can play a useful part in the treatment of malaria.

PALUDRINE

During the war, while we in America were attacking the malaria problem with our customary white-hot enthusiasm, our British cousins were working quietly and without fanfare along slightly different lines. Although British workers came to the same general conclusions regarding the development of the malaria parasite within the human body, their investigations on therapy gave somewhat more original but less spectacular results.

In late 1942, a member of an entirely new series of chemotherapeutic agents was synthesized and tested in avian and human malaria. Although the new substance was only indifferently active in bird malaria and almost inactive in the human variety, British investigators with dogged persistence set about the exploration of the entire series. Eventually, a large number of guanadine compounds was tested; and one, paludrine, was found to be highly active in human malaria. At the same time, its toxicity was shown to be low. Chemically, paludrine is N,-p-chlorophenyl-N_5 isopropyl-biguanide.

In activity, paludrine appears to resemble atabrine—that is, it attacks the asexual blood parasites of all species but has no activity on the sexual and exoerythrocytic cycles. It cures *falciparum* malaria and terminates attacks of *vivax*, but does not prevent the latter from relapsing. It does not act with the rapidity of aralen in controlling temperatures or freeing the blood of parasites. In vivax cases, about 10 per cent are still febrile on the fourth day of treatment and a few on the fifth day.

While paludrine, at present, does not appear to be as effective as aralen, its importance to the world lies in the fact that it represents a new departure in malaria therapy, for hitherto all important antimalarials were members of the acridine or quinoline groups. Since many of the large series of guanadine compounds showed good antimalarial activity, the prospects for finding other members of the group

which may exhibit interesting properties in the treatment of other protozoan diseases seem bright indeed.

D.D.T.

For the larger aspect of man's struggle against the malaria parasite, the development during the war of D.D.T. (dichloro-diphenyl-trichlorethane), may, perhaps, have even greater potentialities than the synthesis of new drugs for treatment and suppression. Unlike other agents used to combat malaria by destroying the intermediate host, the anopheles mosquito, D.D.T. can be used effectively on both the adult and larval forms. Its use as a larvicide, especially when sprayed from aeroplanes, has produced dramatic results in abolishing mosquito breeding. In this way, vast swamps, which would require thousands of man-hours of labor for adequate control by older methods, can now be cleared of mosquitoes and malaria in a few minutes. The widespread use of D.D.T. sprayed from aeroplanes must await further careful studies on the possibly disastrous effects of upsetting the balance of nature and of destroying such useful insects as bees.

However, these considerations do not enter into the use of the preparation to control adult mosquitoes. A 5 per cent solution of D.D.T., sprayed upon the ceilings and walls of dwellings and other buildings, kills all mosquitoes that may light there for a period of many weeks after a single spraying. In many parts of the world, the species of anopheles responsible for malaria transmission invariably choose just such localities as these for daytime resting places. Even if all mosquitoes are not destroyed, the older insects, which are the most likely to have mature sporozoites of malaria in their salivary glands, are the very ones most likely to come into contact eventually with a sprayed wall or ceiling. In areas where the principal vectors are less domestic and choose trees and foliage as daytime resting-places, this method of control will, of course, be much less effective.

SUMMARY

Malaria has exercised a profound influence on the history and progress of the human race. Its parasite is one of the most successful creatures of all time when it comes to perpetuating itself. Until recently man has fought a losing battle with the plasmodium. During the last three centuries, the struggle has become less one-sided as man has acquired, one by one, new and potent weapons against this insidious aggressor. Before the onset of the recent war, we already had quinine, plasmochin and atabrine, plus technics for destroying the breeding places of the mosquito. During the war, we developed aralen, paludrine and SN 13276 as specifics against various forms of malaria, and that remarkable larvicide, dichloro-diphenyl-trichlorethane, popularly known as D.D.T. If used in the light of our newer knowledge of the natural history of the parasite, these weapons, and those yet to come, promise mankind an ultimate though still distant victory.

170 Varick Street

PHYSICAL THERAPY M.D.s NEEDED

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THE OCCLUSION DRESSING IN THE TREATMENT OF DERMATOSES

O. J. Sokoloff, M.D., New Brunswick, N. J.

Constant trauma is one cause of the refractoriness of tissue repair. The "scratch, itch, scratch" cycle is well known to dermatologists. Trauma, in the form of continuous soaks, dressings and repeated applications of various medicaments, is less obvious. Therefore, it occurred to me that perhaps tissue healing might be impeded by the methods generally employed. Conversely, it appeared that healing of various dermatologic lesions could be greatly promoted by the application of occlusive dressings.

Occlusion as a therapeutic procedure is not new, since it is frequently employed by the dermatologist and pediatrician in the treatment of infantile eczema. A second illustration of its use is the Unna Boot for varicose ulcers. Another instance is the employment of the vaseline pack and the plaster of paris cast in the Orr treatment of osteomyelitis.

Manifestations of Koebner's phenomenon are not uncommon. This is the appearance of new lesions in a linear pattern along a traumatized area occasioned by scratching. Typical examples occur in psoriasis and lichen planus. This suggests a touchstone for the merits of the occlusive dressing in the prevention of traumatic manifestations, and allows assay of its relative value in dermatologic therapy in comparison with the measures in common usage.

It was arbitrarily decided to use the occlusive dressing on lesions involving the limbs because (1) of facility of application; and (2) the occlusion could be maintained more easily in these areas.

Three technical approaches were employed, each with occlusion as the basis. The first series of cases combined 4 per cent crude coal tar with occlusion. The second utilized a combination of 3 per cent boric acid ointment and occlusion. The third utilized occlusion without further medicaments. These methods were standardized against those in common usage.

TECHNIC

The lesions were first anointed with a generous amount of ointment. In our study, either 4 per cent crude coal tar or 3 per cent boric acid were the medicaments of choice. The anointed area was then covered with gauze pads. A two-inch bandage then covered the entire involved area. A figure-of-eight type of bandage was used around the hands, wrists, ankles and feet, and a spiral reverse for lesions on the arms and legs. Care was exercised completely to envelope the edges of the dressing with adhesive tape. The patients were then emphatically instructed that the dressing was not to be removed or adjusted except by the doctor or the nurse. No other medication was administered. The dressing was not changed nor the lesion examined for five days or longer, at which time decision as to the continuation of therapy or final disposition of the patient was made. In the case of occlusion dressing without medication, the technic was identical except for the absence of any ointment.

RESULTS

1. *Ecythma.* (a) Ten cases using either 4 per cent crude coal tar or 3 per cent boric acid plus occlusion were treated on ambulatory status. Dressings were not changed or adjusted for one week. Average length of treatment was two weeks. (b) Five cases of occlusion without medication were hospitalized and treated. Average length of treatment was two weeks. (c) Five cases were treated by cleansing with hydrogen peroxide (half strength) and application of 2 per cent aqueous gentian violet. Improvement was slow. Handling of the lesions was painful. Average hospitalization was about one month. There were no failures in any of these 20 cases.

2. *Epidermophytosis.* (a) Fifteen cases treated with crude coal tar (4 per cent) or boric acid plus occlusion. Treatment was on ambulatory basis. Dressings were changed

once weekly. Average length of therapy was two weeks with complete clearance of lesions in most instances. (b) Five cases were treated with occlusion and no medication on hospital basis. The period of hospitalization averaged three weeks. (c) Five were treated with potassium permanganate soaks and modified Whitfield's ointment when oozing stopped. Average hospital stay was three weeks. There were no failures under any forms of therapy.

3. *Furunculosis.* (a) All cases using occlusion with or without medication were treated on ambulatory status. The average length of treatment was ten days with rapid involution and improvement. Twenty were cleared in one week. (b) Eight hospital cases used hot boric acid soaks followed by sulfadiazine ointment required an average of two weeks. There were no failures under any form of therapy.

4. *Ill defined eczema of hands, arms, legs.* (a) Ten cases using either crude coal tar or boric acid plus occlusion, gave excellent results with a five-day average treatment period. (b) Five cases employing occlusion without medication averaged about eight days. (c) Five treated with crude coal tar applied twice daily required about three weeks each. There were no failures.

5. *Lichen Chronicus Simplex.* (a) The occlusion dressing, without medication, was used exclusively in ten cases. Lesions were markedly improved in one week and disappeared almost completely in two weeks. (b) Five cases using crude coal tar 4 per cent with salicylic acid medication being applied twice daily. Average length before great improvement was three weeks—with almost complete healing in one month. There were no failures with either form of therapy.

6. *Contact Dermatitis involving arms and legs.* (a) All cases using occlusion with or without medication were treated on an ambulatory basis. All cases cleared in one week. (b) Hospital cases treated with boric acid soaks, and 2 per cent Burrow's solution soaks cleared in one week. There were no failures under either form of therapy.

7. *Psoriasis.* All cases were hospitalized. The results of occlusion with or without medication were uniformly poor. In 5 cases, a modified (Goeckerman) routine was tried and these patients improved enough to permit return to work.

8. *Infected Scabies.* (a) Twenty cases under the occlusion regime with and without medication responded in one week each. (b) In five cases, I used sulfadiazine ointment twice daily with "in between" cleansing of lesions. Average duration of treatment about two weeks. No failures occurred in either types of therapy.

9. *Trench Foot with Superficial Dermatoses.* (a) All were hospital cases. Patients receiving occlusion with or without medication cleared in one week. In five cases, I used a paint of 2 per cent aqueous gentian violet twice a day. Duration averaged about two weeks, and there were no failures.

COMMENT

In all, 195 cases have been treated in a comparative series. The results in patients who had occlusion dressings have been gratifying. The only notable failure was psoriasis. The dressings are simple and require infrequent changes—a decided advantage in view of the overtaxed nursing situation and overcrowded clinic or office. The dressing is clean and saves clothing and linen. By employing occlusion, the duration of disability is greatly reduced. The occlusive dressing can be used on ambulatory patients who can be promptly returned to work. Follow-up visits to the dispensary are cut to a minimum. The patient has the reassurance that he is being treated twenty-four hours a day.

Evaluation of results under existing conditions is necessarily on a short-term basis. Constant removals or negligent patients make long-term "follow-up" procedure virtually impossible. The chronicity of dermatoses belie the immediate results. Clearance of lesions is not synonomous with cure. The degree of severity and anatomic distribution were not the same in all cases. Previous therapy was arbitrarily ignored, yet prior treatment certainly had some influence on future progress. No cultures on microscopic slides were included. However, the complete absence of selectivity gave all

dermatoses an equal basis for comparison. All diagnoses and judgments of improvements were made by one investigator. Under the circumstances, the possibility of errors in diagnosis and in proper classification may have altered the final results.

In ecthyma, epidermophytosis, infected scabies, furunculosis, lichen chronicus simplex, ill defined eczema, and trench foot with superficial dermatoses, the occlusive dressing invariably cut down the period of morbidity, time of hospitalization and amount of care required.

With psoriasis, the program was a complete failure. Actually, after one week's trial I discontinued the occlusive dressing because of complete lack of improvement, reverted to a modified (Goeckerman) routine and achieved better than average results. This regime consists of erythema doses of ultra-violet radiation on areas sensitized with 4 per cent crude coal tar ointment.

Success with the occlusive dressing in lichen chronicus simplex leaves me with many doubts. The chronicity of this dermatologic lesion and its long history of remission and relapses prevents me from registering any great enthusiasm.

Contact dermatitis requires special mention. In this condition, determination of the offending agent and its subsequent removal constitutes the scientific ideal. Unfortunately, detailed histories and exhaustive skin testing are often neither feasible nor possible. These procedures require prolonged study and possible hospitalization. I had to treat the cases comparatively without testing. Occlusion affords a rapid, efficient means of contact avoidance without removal from work.

69 Patterson Street

HYPERALGESIA IN APPENDICITIS

Sixty consecutive cases of appendicitis were studied except those with a rigid or tense abdomen. These cases are classified as follows: 37 cases of chronic appendicitis, 14 of acute, 4 of subacute, 3 of appendicular abscess and 2 of subsiding appendicitis.

The method of palpation of tenderness is a deep hyperalgesia as one usually employs in the elicitation of tender points in the abdomen. Six points of bilateral tenderness were found.

Tenderness on the left side was observed in 95 per cent of the cases proved to be appendicitis. Contralateral tenderness of the three points was noted in the majority of cases, less frequently two points, and but rarely one point.

Hyperalgesia was found in appendicitis to extend from the third dorsal to the second lumbar nerves. In the majority of cases the dorsal 10, 11 and 12th spinal nerves were affected. On the right side a greater number of nerves were involved and the nerves exhibited a greater degree of tenderness than on the left. The eleventh spinal nerve presented the maximal degree of tenderness as compared with all other spinal nerves.

In the body wall there are longitudinal and transverse muscle segments in which intersegmental anastamoses of the peripheral nerves may take place. This may in part be responsible for the distribution of hyperalgesia in the peripheral nerves.

Retrocecal appendicitis may be differentiated from diseases of the ureter by eliciting the tender points hereinbefore described and noting their predominance over the tender points elsewhere described in diseases of the ureter.

The following hypotheses concerning hyperalgesia in appendicitis are advocated: (1) Minimal unilateral hyperalgesia in the appendicular reflex is confined to the eleventh dorsal spinal nerve on the ipsilateral side. (2) Minimal bilateral symmetric hyperalgesia involves the eleventh dorsal nerve on the ipsilateral and contralateral sides. (3) Maximal bilateral assymetric hyperalgesia affects two or more consecutive spinal nerves inclusive of the eleventh dorsal, assymetrically and bilaterally, the greater intensity and radiation taking place on the ipsilateral side.

Ten per cent of the cases constituted minimal hyperalgesia and 90 per cent maximal—(Author's Abstract.) Matthew S. Levitas, M.D., Arch. Surg., 44:918-932.

PREMATURE LABOR *

ROBERT A. MACKENZIE, M.D., F.A.C.S., Asbury Park, N. J.

With considerable satisfaction we view the steadily declining maternal mortality rate in New Jersey. Less satisfactory are the figures for deaths of newborn infants. From the tabulation by our efficient Bureau of Maternal and Infant Welfare, the continued high fetal loss in the first days of life is evident.

Chart 1

INFANT MORTALITY

STATE OF NEW JERSEY

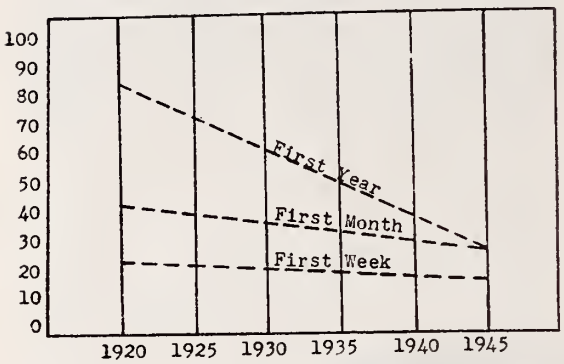


Chart No. 1: Fatalities are most numerous in the first hours after birth, indicating beyond question that an obstetrical approach to the problem is necessary.

It is my purpose here to call attention to the place of premature labor in the picture and make some suggestions toward a greater salvage of the living babies born before term. In 1936 it was my privilege to read before this Society a paper under the title "Causes and Management of Premature Labor". It was my observation then that the majority of premature births occurred in the course of uncomplicated pregnancy and without a cause that could be determined. I have continued to study the premature births in the Monmouth Memorial Hospital in Long Branch and present here the record for the intervening ten years. Unhappily, no progress can be reported either toward greater understanding of premature labor or in reduction of its frequency. The figures do show creditable progress in the protection and preserving of the babies. This paper will call your attention to an important subject and I trust that some of the recommendations may be of value.

Chart No. 2: The frequency of premature births is shown in two periods of five years each and instead of a decline, there is a mounting frequency. The figures are divided for patients who have their own physicians in attendance and those who are cared for on the wards. The ward patients have premature births in much higher ratio than do the private patients. Why this is true is not clear; although it is easy to assume that the group of patients less favored in their economic status have less advantage in nutrition and rest and inadequate prenatal medical care. The total figure for incidence of premature births is 5.58 per cent and this is approximately the same figure reported in country-wide statistics. To make our figures comparable to other series, an infant will be considered prematurely born if the birth weight is under five and one-half pounds. Many of the small infants (one to two pounds) were not viable but are included because it is necessary to report such births to the Bureau of Vital Statistics. Complete hopelessness is not the proper approach to the care of even the tiniest baby. We were happily surprised in the past year by the survival and apparently normal growth of an infant weighing one pound and twelve ounces at birth.

CHART 2

MONMOUTH MEMORIAL HOSPITAL

	Living Births Total	Premature Births	Percentage Incidence of Prematurity
1st five-year period (1936-1940)			
Private	1532	52	3.4
Ward	1685	97	5.7
2nd five-year period (1941-1945)			
Private	3693	188	5.1
Ward	1541	135	9.0
TOTAL	8451	472	5.58

* Read before Section on Obstetrics and Gynecology, The Medical Society of New Jersey, at Atlantic City, May 22, 1946.

CHART 3

FETAL MORTALITY
Monmouth Memorial Hospital
1936-1945

Total number of neonatal deaths	153
Neonatal deaths of "prematures"	90
Total number of stillbirths	222
Premature (88 before labor)	106

	Total Fetal Loss	
	Private Cases	Ward Cases
1936-1940	2.9%	5.8%
1941-1945	3.8%	5.5%

Chart No. 3: These figures show the role of prematurity in keeping up the proportions of fetal loss. Fifty-eight per cent of the total deaths of newborns are prematures. The total fetal loss is lower for patients who have their own doctors than among ward patients, although the number of primiparous women delivered as private patients is much greater in proportion to multipara than on the ward service. The number of operative deliveries is also much higher.

CHART 5

Delivery Terminating Premature Labor

Spontaneous vertex	374
Low forceps	16
Medium forceps	3
Breech	43
Version	8
Cesarean	28
	472

Indications for Cesarean Sections

Placenta previa	16
Fulminating toxemia	6
"Abruptio placentae"	3
Large fibroids	2
Transverse lie	1
	28

Fetal mortality	50%
Maternal mortality	0%

than the manner of birth itself. Half of the babies delivered by cesarean section failed to survive. Hemorrhage and fulminating toxemia were the indications for the abdominal section in twenty-five of the total of twenty-eight cases.

CHART 4

Birth Weight	Number	Neonatal Deaths					
		1st Hr.	Next 23 Hrs.	2-7 Days	7-14 Days	Total	%
1 to 2 lbs.	20	14	4	1		19	95 %
2 to 3 lbs.	32	16	6	3		25	78 %
3 to 4 lbs.	46	8	4	5	6	23	50 %
4 to 5 lbs.	150	5	5	4	3	17	11 %
5 to 5½ lbs.	224	2	0	3	1	6	2.7%
	472	45	19	16	10	90	

In previous study:
We lost 83% of infants under 3 lbs.
60% of infants between 3-4 lbs.
24% of infants between 4-5 lbs.
16% of infants between 5-5½ lbs.

Chart No. 4: The greatest number of deaths (71 per cent) in the neonatal period occurs in the 24 hours following birth. This is ample evidence of the need for an obstetrical viewpoint in the effort to salvage more of these infants. Encouragement can be derived from the comparison of the losses in the different weight groups from the results obtained and reported in 1936.

Chart No. 5: The manner of delivery is shown but no attempt is made to tabulate the fetal loss according to the technic of delivery. Statistics of this kind have no value. The fate of the baby depends upon many things other

Obviously these babies were gravely handicapped. The recovery of 100 per cent of their mothers was a source of satisfaction to all concerned. Breech presentation is especially hazardous for prematures. Best results follow spontaneous vertex and outletforceps deliveries.

Chart No. 6: In infants weighing under three pounds at birth, immature development was unquestionably the greatest factor in the failure to survive. A previous table shows that thirty of the forty-four lived less than one hour and of the remaining fourteen, ten were lost before the end of the first day. With a birth

CHART 6

Analysis of Neonatal Deaths

44	under 3 lbs at birth—Prematurity alone the major factor	
23	weighed only 3 to 4 lbs at birth—Prematurity largely responsible	
23	weighed over 4 lbs.	
	Trauma or asphyxia during birth	15
	Erythroblastosis	3
	Congenital malformation	4
	Pneumonia	1
90		

Autopsy in 28 cases

weight of over four pounds, the cause of death was attributed to trauma or asphyxia during labor in fifteen cases, with hemorrhagic phenomena demonstrated by postmortem examination in thirteen of these cases. Gross congenital malformation was the cause of death in four cases, two of which would have not been established as such except by the autopsy. Erythroblastosis was the cause of death in three and pneumonia in one. While postmortem examination does not seem as illuminating in premature infants as compared to infants born at term, it is important to obtain permission for necropsy in every case. There are occasional surprises and much to be learned in every case which comes to such study.

CHART 7

Factors Contributing to Premature Labor

Factor	No. of Births	Percentage Incidence
Multiple pregnancy	84 (44 mothers)	18.0
Premature rupture of membranes	36	7.6
Toxemia (all types)	34	7.2
Hemorrhage	31	6.6
Placenta previa 22		
Abruptio placenta 9		
Syphilis	14	3.0
Hydramnios	7	1.5
Others	5	1.1
Total	211	44.7%

Chart No. 7: As in reports of other observers, multiple pregnancy leads our list of factors contributing to early emptying of the uterus. Hydramnios not associated with twinning occurred in seven other cases. In both of these groups, the overdistention of the uterus offers a reasonable explanation for the stimulation of uterine activity.

Premature rupture of the membranes without exciting cause occurred in 36 cases. This group received special study and here I was able to note substantiation of observations by others that youth and primigravidity were factors. Twenty-one of these patients were primigravidae under 22. General health was excellent and behaviour not unusual in these women. Neither coitus nor any other excitement preceded the discharge of amniotic fluid. Presumably this occurrence is due to weakness of, or a defect in, the amniotic sac. Signs of toxemia were noted in the next largest group—disturbance of the electrolyte balance with oedema being obvious in most.

The 31 cases of antepartum bleeding are divided into those with diagnosis of placenta praevia and so-called abruptio placentae. No accuracy of differentiation is claimed since all are instances of premature separation of the placenta and the exact position of attachment cannot always be determined. From the viewpoint of prognosis this group stands below all other cases. Salvage of babies was low—threat to life of the mother great.

Fourteen patients had positive Wassermann reactions. Syphilis looms large in responsibility for stillbirths but not in provoking premature labor.

A few instances of coexisting pathology—ovarian or uterine tumor, one case of double uterus, and one of febrile illness (pneumonia) might be mentioned. It was encouraging to note that there were no instances of repeated premature labors comparable to "habitual" abortions.

POSSIBLE PREVENTIVE MEASURES

Study of the "causative" factors noted above does not show the way to prevent onset of premature labor in many cases. Toxemia may be reduced in frequency or in severity at least by special attention to the overweight patient and one with a previous history of toxemia. One or two grains of thyroid gland substance given daily where obesity is present seems to be advantageous. Preliminary test of the basal metabolic rate does not seem necessary. Intake of fluids and salt should be restricted in these cases also. Where there is excessive size and

tension of the uterus confirmed by reexamination after one or two weeks, x-ray examination may well be made to diagnose multiple pregnancy or a possible malformation of a single fetus. Except where faulty development is evident, activity of the patient should be restricted and sedatives given to aid comfort and reduce irritability of the uterus.

There is one measure of positive preventive value: sterilization immediately postpartum in cases of repeated severe toxemia. Where hypertension and albuminuria have complicated repeated pregnancy, the thoughtful obstetrician must wish to protect his patient against certain eventual tragedy. These are actually cases of disease of the peripheral arterioles with nephrosclerosis. Tubal ligation on the second, third or fourth postpartum day—a simple operative procedure which may be performed under pentothal intravenous anaesthesia or with novocaine infiltration—will be welcomed by many of these patients.

Influencing thus only a very few cases, it appears that little can be done to reduce the frequency of premature labor. A thorough examination including medical history and test of serology should be made, of course, early in pregnancy. With findings normal, there can be no value in restricting a patient's activities or imposing a burdensome program of medication, special exercises, et cetera. During the war years, many wives traveled much and followed few of the cautions customary in pregnancy without apparent ill effect. The role of emotional unrest in stimulating uterine contractions is impossible to evaluate. It is my personal impression that excessive nervousness has nothing to do with premature labor; but the woman who is relaxed and confident during her pregnancy has many advantages and I believe normal patients do better when examination during most of the prenatal period is superficial and only in the final weeks is attention given to evaluation of the pelvis, determination of the fetal position, and plan for delivery.

MANAGEMENT OF PREMATURE LABOR

It is a common but incorrect impression that because a baby is small, labor will be easier before term. The rigidity of the soft tissues and the inefficiency of uterine contractions more than counteract the slight advantage of a small baby and tax the obstetrician's skill in managing the often prolonged course of labor. The two most striking characteristics of the premature infant are the susceptibility to injury (particularly to intracranial injury), and the poorly functioning respiratory center. The difficulties of digestion and low resistance to respiratory infections which complicate the later progress of prematures will never be faced by the pediatrician if the obstetrician does not do his part well. The blood vessels are extremely fragile and the intricate system of vascular channels within the cranium does not have the protection afforded by the vault as in a child at term. Therefore the baby faces great hazard in passage through the birth canal and in the handling immediately after delivery. Compression of the head by uterine contractions, molding in descent through the pelvis, and the pull of instruments all tend to injure blood vessels and do damage to the membranes of the brain. Under the influence of anoxia, diffuse petechial hemorrhages may occur in any part of the body with most serious effect if in the adrenals or in the brain. The respiratory center is depressed by trauma and by the influence of barbiturates or morphine given to the mother. Obviously then, and speaking in generalities, drugs should be given early and only in small doses to the woman in premature labor. General anaesthetics must be administered briefly or not at all.

But much can be done to relieve a suffering mother without sacrificing the baby's chance for survival. I refer to the use of local and regional anaesthesia. Here, I want to mention my own satisfactory experience with local infiltration of novocaine into the perineum and with pudendal block, also in the past four years with intraspinal anaesthesia injection in small doses. By local infiltration alone, episiotomy can be made painless and it is good sense to relieve the resistance of a rigid perineum in this way. Anaesthesia of the entire lower birth canal is obtained by pudendal block, which also softens the tissues of the pelvic floor. This is used by some obstetricians even before the cer-

vix is fully dilated in the belief that it affords aid to relaxation of the cervical ring. By injecting 50 milligrammes of procaine into the spinal canal between the fourth and fifth lumbar vertebra relaxation of the cervix and vagina is effected while giving from 60 to 90 minutes' complete relief from all pain except the sensation of the still actively contracting uterus. I have found low spinal anaesthesia particularly useful in breech presentations and for the delivery of twins. Pudendal block suffices for almost every case of vertex presentation even where the use of outlet-forceps is necessary.

Among the general measures of greater importance in premature labor than in labor at term is the use of vitamin K. A report from the Chicago Lying-In Hospital based on study of fetal mortality from 1941 through 1944 seems to relegate vitamin K to the long list of promising therapeutic agents which have failed to stand the test of time. It is theorized that a reduced prothrombin level is not a real contributing cause to birth trauma. And in true hemorrhagic disease of the newborn—fortunately very rare—there are other factors which make vitamin K of no value. There now seems no sound basis for the use of vitamin K routinely in all obstetrical cases. But in premature labor with blood vessels of marked fragility and the near certainty that slight hemorrhages will result from the pressure and molding of the fetal head, the hypodermic administration of vitamin K both to the mother during labor and to the infant after birth seems very wise. Tiny internal hemorrhages may not cause death but may influence early or later development of the child adversely. It seems important to prevent the physiologic fall in blood prothrombin level between the second and fifth days of life which might increase the importance of these lesions. This accomplishment of vitamin K has been established beyond question and it seems especially necessary where barbiturates have been given.

Special management of premature labor depends upon the complicating factors which may be present. It has been said that to manage premature labor intelligently one must be acquainted with the underlying or associated pathological conditions and skilled in measures to treat the unusual.

MULTIPLE PREGNANCY

In multiple pregnancy uterine inertia is usually present. The general condition of the mother may be embarrassed by anemia or exhaustion. Partial breakdown of the kidney function may be a coexisting complication. Completion of the first stage of labor may require many hours and attention must be directed to conserve the patient's strength through judicious use of medication for relief of pain and by keeping up the patient's fluids. Infusions of dextrose solutions should be given without waiting for signs of exhaustion or acidosis. The blood count should be checked in every case of twins and the blood typed and tested for the Rh factor in anticipation of possible need for blood replacement. Operative interference is often necessary particularly to effect delivery of a second baby. Abruption of the placenta may occur following reduction in the size of the uterus after the birth of the first child. Postpartum hemorrhage is frequent. The use of low spinal anaesthesia has already been mentioned. Either this or pudendal block will greatly facilitate management of the second stage of labor.

PREMATURE RUPTURE OF AMNIOTIC SAC

In my practice, three instances within the last year have demonstrated the value of conservative management following premature rupture. In one case the mother of one child aged nine remained in bed for eighteen days at home in the care of a nurse. Active labor then began, hospitalization was arranged and delivery of a living child weighing four pounds and ten ounces was accomplished—breech and single leg presenting. The baby's progress has been excellent. In a second case, also a breech presentation, the mother occupied a hospital bed for eight weeks. Delivery of the breech was successfully conducted under the method of low spinal regional block previously described. The baby weighed four pounds fourteen ounces and has made normal progress. In the third instance, escape of amniotic fluid was noted in the twenty-third week of the

pregnancy. After a week of care at home, the uterus seemed to be active and the patient reported a show of blood. In the hospital she was given sedatives and the foot of the bed raised. Five and a half weeks later, by spontaneous process of labor, a three-pound twelve-ounce baby was born. This baby also has done exceedingly well. These cases are cited to offer encouragement to conservative management of patients with punctured membranes. It is recognized that intrauterine contamination must be expected in these cases even without vaginal examination. Introduction of antiseptics into the vagina is routinely practiced by a number of prominent obstetricians. It is not done in our Montmouth County hospitals, however, and our morbidity figures are good. In the three cases cited there was no elevation of temperature postpartum.

Where premature rupture of the membranes occurs in a case where the baby lies with feet presenting in the cervix, prolapsus of the legs through a firm cervix is very likely to take place. Obstruction of the cord and loss of the baby is the usual course. Even though one gives up hope for the baby's survival and lets nature take its course, delivery of the shoulders and head may be extremely difficult because the cervix may not thin out and dilate as the slender body passes through. Injury to the cervix must be avoided to protect the patient at the time and to preserve her good condition for future childbearing. It is safer, I feel, in this particular situation to employ a hydrostatic dilator. A large size Voorhees bag can be readily introduced through a cervix with a two to three centimeter os, and by the time the bag is expelled the baby can be readily delivered with a better chance of life than would have been the case were the dilator not used.

BLEEDING IN LATER PREGNANCY

When vaginal bleeding occurs after the fourth month of pregnancy and no local cause in cervix or vagina is apparent, it is well to assume that there is a low implantation of the placenta. Unusual quiet afforded to such a patient may prevent further bleeding until the pregnancy is well advanced and the fetus viable. It is not my opinion that presumption or diagnosis of placenta praevia is a justification for hurried interference. With every preparation for blood replacement made in anticipation of need, a patient may be kept at rest for many weeks even after fairly profuse painless bleeding. Within the year past a young woman experienced vaginal bleeding in the twenty-seventh week of her second pregnancy. Without any examination she was confined to her home for three weeks—then after another hemorrhage kept in bed also at home for two weeks, and for two more weeks observed at the hospital. In the thirty-fourth week of her pregnandy a Cesarean section was performed and a five-pound fetus delivered. Central placenta previa was demonstrated at the operation. Transfusion was unnecessary. When bleeding is profuse or the dangers involved in further waiting make it imperative to proced to terminate the pregnancy, what is the safest course? Treatment of placenta praevia has been practically reduced to two courses; i. e., either perform Cesarean section or puncture the membranes. The Voorhees bag has been almost completely discarded in management of hemorrhage. The same choice of measures must be made also in cases of abruptio placentae where the bleeding is profuse, the uterus tetanic, the patient in great pain and often in shock. Vaginal examination with the most careful sterile precautions determines whether or not the cervix is effaced and dilatable. Cesarean section is certainly the safest procedure when the cervix is thick and unprepared for dilatation. The baby's chances of survival are very much favored by prompt abdominal section in cases of major abruption whether the placenta be high or low in position. The poor record of survival of the babies delivered by Cesarean section as shown on the accompanying chart is not an indication of poor management in my opinion.

TOXEMIA OF PREGNANCY

In toxemia, the problem is largely one of a course to follow in terminating the pregnancy. Shall the uterus be stimulated to empty itself or be evacuated by abdominal section? This is not strictly the management of labor, but appreciation of the dangers to the fetus in the

protracted labor which may follow induction of labor by puncture of the membranes may throw the choice to Cesarean section when the salvage of the baby is of special importance. In severe toxemia the baby's chances are seriously curtailed anyway by the effect of the toxins circulating in the maternal and fetal blood. During labor or during the cesarean delivery, administration of oxygen to the mother (which can be done with local or spinal anesthesia) gives the baby much benefit.

Decision as to the exact time to interfere requires most delicate judgment. The possible value of delay in advancing the baby's maturity must be balanced against the effect of the increasing toxemia upon the child and considered along with the best interest of the mother herself.

MANAGEMENT OF THE NEWBORN

As to the management of the newborn, the first concern should be to clear the nasopharynx of foreign material. Inverted position of the baby and gentle stroking of the throat evacuates the greater part of the mucus in the nostrils and mouth. Aspiration of the pharynx should also be done and even use of the laryngoscope and tracheal aspirator is indicated in cases of asphyxia where obstruction of these passages must be assumed. When respiration is not spontaneously established, introduction of oxygen directly into the trachea under controlled pressure or use of the respirator must be promptly initiated. Injections of lobelin are of little or no value. During these early moments of life the slender store of body heat in the infant must be preserved and efforts to revive the child should be made only after placing him in a heated bed. The receiving blanket must be warmed. Chilling dangerously depresses the infant's vitality. Premature babies delivered in hospitals have a much better chance for survival than those born at home where little preparation to maintain the infant's meagre reserve of body heat or support to failing respiration can be offered. But upon those of us who approve the hospitalization of all obstetrical patients there is real responsibility for protecting premature babies from the effect of drugs used too liberally for relief of the mother's pangs of labor and from a reception which fails to take into account their special need for gentleness, warmth and oxygen.

SUMMARY

Figures are presented showing premature births in the Monmouth Memorial Hospital over a ten-year period. Possible causes of the unexpectedly early labor were noted in only 44.79 per cent of total number of cases. Survival of the babies depends upon the degree of development as indicated by weight and conditions attending the birth. Highest fetal mortality was recorded in the cases of hemorrhage.

Special characteristics of the immature fetus of importance to the obstetrician have been noted. Suggestions are offered to minimize the danger of birth trauma and attention called to the premature infant's sensitiveness to drugs and anesthesia.

Management of premature labor is discussed in relation to complicating conditions. Illustrative cases show that premature rupture of the membranes need not be followed by expulsion of the baby within a few days. Conservatism is urged in management of this condition and of antepartum bleeding to gain a more mature baby.

501 Grand Ave.

NEW ANTISEPTIC SOLUTION

Having set up standards for the ideal antiseptic for topical application, E. A. Brown, W. Krabek and R. Skiffington (*New England J. Med.* 234:468, 1946) found that while hydrogen peroxide possessed the greatest number of requirements among available antiseptic solutions, it is not stable and its action on bacteria is too transient. It occurred to these workers that these disadvantages could be overcome by the use of carbamide (urea) peroxide as a source of hydrogen peroxide in anhydrous glycerine as a solvent. The solution consists of 4 per cent carbamide peroxide in substantially anhydrous glycerine. The mixture was successfully used by over 30 physicians on hundreds of patients in studies extending over a period of four years.

PROTEIN HYDROLYSATE OINTMENT

A PRELIMINARY REPORT

By Paul C. Wiesenfeld, M.D., Perth Amboy, N. J.

Proteins in the form of amino-acids have long been advocated in cases of edema, delayed healing, loss of body fluids, allergies, cirrhosis, gastro-intestinal diseases, hypochromic anemia, pregnancy, nephrosis and many other disorders.

Every living cell contains protein—skin, hair, tendon and muscle are chiefly protein in nature. The nerve and bone systems contain large amounts of protein substance; all the enzymes and some of the hormones are proteins. This list can be extended to include all the tissues.

NON-ESSENTIAL AMINO-ACIDS

About half the known amino-acids can be synthesized in the body. The ones that cannot have been called "essential"—an arbitrary term since the so-called "non-essential" acids are also indispensable though they are produced by the body in sufficient amount for normal growth. For example—glycine would be labelled "non-essential" in that the body supplies sufficient for every day use; yet it is indispensable in the most basic and ordinary body mechanisms such as muscle action.

ESSENTIAL AMINO-ACIDS

Some of the more common "essential" amino-acids are: (1) *tryptophane* (A amino-B indole—propionic acid) which is required for maintenance of body weight; (2) *lysine* needed for growth; (3) *tyrosine* for use as a base in adrenaline and thyroxine; (4) *cystine* is required to form glutathione (growth takes place more rapidly if adequate amounts of the former are available), and (5) *hisitidine*.

AMINO-ACIDS AND VITAMINS

A striking similarity has been noted between aminoacids and vitamins. Quick [1] has pointed out that both take part in important physiologic mechanisms; and that lack of an adequate quantity of either results in a well defined pathologic state unless the deficiency can be synthesized. Thus, lack of ascorbic acid causes scurvy in the guinea pig but not in the chick; yet absence of glycine brings retarded growth in the chick but no change in the guinea pig. Thus one could almost consider glycine a vitamin for the chick.

AMINO-ACIDS IN PROTEIN

From a nutritional viewpoint it is important that the amino-acid content of proteins be established. Then the "essential" and "non-essential" amino-acid requirements should be determined. This can be done by three methods:

1. Inclusion of a single purified protein in a ration.
2. Feeding mixtures of amino-acids.
3. Feeding a protein hydrolysate after chemical removal of one or more of its constituent amino acids.

It has been shown by Van Slyke and Meyer [2] that injected amino-acids are avidly taken up by the tissues. Hepatic tissue took up more per unit of weight than muscular tissue. Feeding of protein to a fasting experimental animal results in an increase in hepatic protein. The protein enrichment of the liver which follows the ingestion of a diet high in protein is associated with an increased content of protein per unit weight of tissue as well as with hyperplasia or hyperthrophy.

On fasting, the quantities of protein lost by various organs and tissues of the body vary considerably. Thus in a seven-day fast in rats the proportionate loss varied from the liver (40 per cent) to the eyes, testicles and adrenals (no loss). The muscle, skin and skeletal system lost 8 per cent.

RESERVE PROTEIN

During the last decade there has been considerable discussion of "reserve protein", a type of protein analogous to glycogen for the

1. Quick, A. J., in Sahyun, Melville, *Outline of the Amino-Acids.*
2. Van Slyke, K. K., and Meyer, in *Outline of Amino-Acids,* ibid.

storage of amino-acids. But there is little evidence for the presence of any protein which has as its sole function the storing of amino-acids.

It has not been found possible to single out on a chemical basis any particular reserve or storage protein. Borsook and Dubnoff [3] have pointed out that it is possible to distinguish reserve protein, not by a difference in composition but by location. Thus in a course of a wasting disease or a fast, "labile" proteins would be taken from muscles and be resynthesized into liver and kidney protein, but this cannot be worked in reverse. For instance, in a muscle wasting disease (e. g. progressive muscular atrophy, poliomyelitis, etc.) there is little synthesis of the liver and kidney protein into muscle protein.

PROTEIN IN THE DIET

The daily protein requirement is one gram of effective protein per kilogram of body weight. To be assured of a proper intake, the figure of 100 grams of protein daily (especially in the form of eggs, milk and meat) is usually given.

Bloch [4] has tentatively suggested that for optimal nutrition, the average man should ingest each day from 3.5 to 4 grams of cystine plus methionine; 4 to 5 grams of arginine; 5 to 6 grams of lysine; 1 to 1.25 grams of tryptophane; 4 to 4.5 grams of phenylalanine; 3.5 grams of threonine; 10 grams of leucine; 4 to 4.5 grams of valine and 3 to 3.5 grams of isoleucine.

We all tend to be on the low side when taking protein. Beard [5] found the average daily intake of protein was only 77 grams in a study of the self-selected diets of 400 medical students.

Orr and Gilks [6] dramatically demonstrated the value of generous protein diet. They studied two adjacent African tribes who had different dietetic habits. Citizens of the tribe with a high protein content were five inches taller and fifty pounds heavier than their neighbors who were vegetarians. The former also had 50 per cent greater muscle power.

It seems reasonable to conclude that if normal individuals take inadequate proteins, sick ones, who might need more (because of increased catabolic processes), would certainly require additional proteins.

PROTEIN FOR MUSCLE DENERVATION

Solandt [7] has pointed out that "infantile paralysis results in a denervation of skeletal muscles which differs in no way from traumatic denervation". And Gutmann [8] and Hines [9] have shown that the return of muscle function after crushing of a nerve, is expedited by high protein intake. On this basis, the author has studied the effect of inunctions of protein hydrolysate on twelve cases of poliomyelitis.

CLINICAL RESULTS

The group consisted of twelve children who had had acute anterior poliomyelitis during the past year. Most of them were in-patients at the Poliomyelitis Convalescent Center in New Brunswick, N. J. All were under the care of the same physiotherapist, all are now in the stage of muscle re-education. Results were checked at regular intervals, all by the same observer, to minimize personal errors. Since only four months have now elapsed since initiation of treatment, results are admittedly tentative but this report is published in the hope of activating other observers to make similar studies.

In our cases, only slight and negligible increases were noted in circumferential measurements, averaging about ¼ inch increase in the thigh. There was a gratifying increase in muscle tone, color and appearance of the limb to which the hydrolysate had been administered. In every case the limb showed a marked difference obvious even to the most casual observer. Whether this will be permanent remains to be seen, but there appears to be no lessening in the change as noted. If anything, it seems to be improving. There is the possibility that the slight amount of massage associated with the administration was the cause of the improvement. To check on this, it will be our future

3. Borsook, H., and Dubnoff, J.: Journ. Biol. Chem. 132: 307 (1940).
4. Block, W.: Zeitschr. Physiol. Chem. 239:236 (1936).
5. Beard, H. H.: Annual Review of Biochemistry 10:246 (1941).
6. Orr, J. B., and Gilks, J. L., in Chapter LVIII, *Physiologic Basis of Medical Practice*, Best & Taylor.
7. Solandt, D. Y.: Annual Review of Physiology, 1945.
8. Gutman, E.: Journ. Neurology & Psychiat. 5:81 (1942).
9. Hines, H. M.: Amer. Journ. Physiol. 137:527 (1942) and ibid. 55:97 (1944).

policy to use cold cream massage to the opposite limb as a control.

TECHNIC

A protein hydrolysate ointment * is used. This is prepared in an endodermic and easily absorbed base and is applied to the affected limb twice a day over an area of three by four inches. The ointment is gently rubbed in until it is absorbed, a process which usually takes about five minutes. The site of inunction is shifted daily so that in about three days the entire limb can be covered.

SUMMARY

The necessity for increased protein intake and absorption in wasting diseases is emphasized. Protein hydrolysate ointment was used on the atrophic limbs of twelve children who had had poliomyelitis with encouraging results in improved muscle tone.

138 Market Street

NIGHT VISION AND ULTRAVIOLET LIGHT

"Experiments with baby chicks reveal that exposing eyes to high intensities of invisible ultraviolet light ranging from 300 to 365 millimicrons in wavelength — a range previously considered harmless by some authorities—delays dark adaptation and impairs visual functions even though no obvious changes in the eyes can be observed," according to an article appearing in *Hygeia*.

The author, E. D. Tillyer, Sc.D., is research director of the American Optical Company.

Reviewing the work of Wolf of the Harvard Biological Laboratories, the author states that "as human eyes could not be utilized because of the potential danger, the Harvard biologist selected baby chicks for the testing purposes as the visual characteristics of their eyes approximate closely those of a human being."

Dr. Wolf recommends, in view of his findings on ultraviolet light, that "in order to preserve efficient night vision protective lenses excluding these dangerous rays should be worn by welders and their helpers, skiers, fliers, sun bathers and others exposed to high intensities of these radiations."

The author explains that light rays can be accurately measured by means of laboratory devices. Visible light rays range in length from about 400 to 750 millimicrons. The invisible ultraviolet region starts below 400 millimicrons and includes shorter waves until air absorbs them around 190 millimicrons.

The excessive ultraviolet rays encountered in welding operations, in the arctic regions or at the seashore may cause eye damage ranging from slight irritations to severe burns.

The article points out that the "welding arc emits ultraviolet rays ranging from 190 millimicrons to the visible region.

N. J. MEDICAL CARE PLANS PRAISED BY CHICAGO PROFESSOR

The following article appeared in the July 23 Newark *Evening News*, and is published here for the interest of our members:

CHICAGO—The Medical Service Administration and the Medical-Surgical Plan of New Jersey offer one of the most varied and flexible programs among all the professionally operated "health insurance" services in the country.

This was stated today by Herbert Simpson, professor emeritus of public finance at Northwestern University. Acting for the National Physicians Committee for the Extension of Medical Services, Professor Simpson released conclusions reached in a study of doctor-operated voluntary medical care plans in six typical states.

Particular attention is given to those aspects of the New Jersey plan covering special groups and with cooperation of governmental agencies. They are the Farm Security Plan, the Newark Plan and the Veterans Service.

A pioneer in the field of paid medical service for the indigent, the Newark Plan provides care, with free choice of a physician, for those whose names appear on the welfare rolls and are confined to their homes by illness. The city pays for the doctors' calls through the Medical Service Administration.

The Farm Security Plan is a voluntary prepaid medical service system operated in conjunction with the Farm Security Administration. In other states similar plans have failed because of lack of interest among the farmers. But in New Jersey some 50 per cent of eligible families are participating.

For $15 to $24 a family the plan provides payment for physicians' services in home or office. Hospital service is not included in the plan but an annual general physical examination is provided.

Outstanding in the Jersey Plan, according to the report, was its success in avoiding financial pitfalls which nearly wrecked other plans launched about the same time. By limiting coverage to unusual-expense sickness and reducing the rate from that necessary to cover complete service, even for minor treatments, the plan got off to a sound financial start.

* The material was furnished by the Rutlee Chemical Company of Perth Amboy which manufactures this ointment under the proprietary name of "Protam."

STATE ACTIVITIES

VETERANS CARE PLAN

HINTS TO PHYSICIANS CARING FOR VETERANS

By Edward T. Yorke, M.D., Liaison Officer

A veteran is entitled to outpatient treatment at government expense for service-connected disabilities only. Eligibility for this care (both as regards service-connection and veteran status) is determined by the Veterans Administration. The V. A. is the sole authority for issuance of authorizations for treatment.

CONSULTATIONS

The V. A. recognizes only one physician in the mechanics of giving authorization for medical care of a veteran.

Requests for consultation are made by the original physician on the case. The consultant may render only the type of service actually authorized. When he believes certain other studies are warranted, he makes this known in his report to the initiating physician, who then requests authorization from V. A.

Knowing exactly what the specialist may want to do, the initiating physician may authorize such specific studies at the outset, dispensing with a formal consultation.

When the specialist is to take over the treatment of the veteran from his standpoint, all requests for such treatment must be relayed to the initiating physician, who then obtains authorization from V. A. in the name of the specialist. The veteran may be under the care of more than one doctor at a time, but there is only one physician holding the reins with regard to requesting authorizations.

PRESCRIPTION SERVICE

If the neighborhood pharmacy has agreed to go along with the N. J. Pharmaceutical Association in supplying prescription service in the V. A. medical care program, the veteran need not send the prescription to Newark for filling.

The physician whose prescription is to be filled in the local pharmacy is required to make the following statement on the prescription:

"I am authorized to treat and prescribe for the above-named Veterans Administration patient." This may be written, typed or stamped upon either side of the prescription blank.

Show on the prescription the (1) name and (2) address of the patient and (3) the date.

See page 388 of this Journal for further details about the V. A. prescription service.

BILLS FOR TREATMENT

Experience has taught that billing the Veterans Administration for services rendered to the veteran in the medical care program is an exact science. (It isn't how one feels about it but how one does it.)

Never include in your bill anything that has not been previously authorized by the V. A. The authorization itself is an absolute guide to the items that you may put in your bill.

Clerical difficulties within V. A. prompt one to advise that you bill the V. A. once monthly, including in the one bill all authorized services rendered. The specimen statement below includes the billing of two separate cases. More may be added. Do not total each case; total the whole bill. Prepare the bill in triplicate; keep one carbon; send the original and one carbon to V. A.

Don't forget the certification at the end of the bill.

Note that the claim status as well as the veteran's name is given. Show his claim number or indicate "claim pending". The diagnosis is not difficult. As for treatment, merely state "medical", "surgical", "consultation", "physiotherapy" or other special procedure. Details are not required. You will have submitted an individual treatment record for the veteran's file.

Every item in the fee schedule has a claim number. These numbers were printed on pages 39 to 44 of the February (1946) Journal. It is helpful if you write the number before each item on your bill, though this is not needed for the routine "house call" or "office call".

Use your own billhead or office stationery. No one may charge for the service except the doctor to whom authorization was issued: Keep the authorization. Do not mail it in with your bill. Send the bill to Veterans Administration, 20 Washington Place, Newark 2, N. J.

The following specimen shows a bill (for 2 patients on one statement) properly filled out:

SPECIMEN BILL

JOHN Q. SMITH, M.D.
1492 Columbus Avenue
Ozone, New Jersey

Oct. 1, 1946

To: Veterans Administration
20 Washington Place
Newark 2, N. J.

For Professional Services Rendered:

DOUGHBOY, John I. C 4 665 892
Diagnosis: Duodenal ulcer, chronic.
Treatment rendered: medical.

Office calls: Sept. 4, emergency	$ 3.00
Sept. 8, 12, 15, 21, at $3	12.00
1065. Chemical examination, routine, of urine, Sept. 8	1.00
1032. Complete blood count, Sept. 10	5.00

ZILCH, Franklin Maxwell, C—pending.
Diagnosis: Malaria.
Treatment rendered: medical.

Office calls: Sept. 6, 12, 16 at $3	9.00
1015. Blood smear for malaria, Sept. 6	2.00
Total bill (two cases)	$32.00

I certify that this account covering my services in these cases is correct and just and that payment therefor has not been received.

(signed) JOHN Q. SMITH, M.D.

INSTRUCTIONS TO PHYSICIANS RENDERING OUTPATIENT CARE TO VETERANS

This information is furnished by the Regional Office of the Veterans Administration, 20 Washington Place, Newark.

Under existing Veterans Administration regulations out-patient treatment may be rendered by local physicians in the following cases:

1. To veterans seeking treatment for conditions which have been previously adjudicated by the Veterans Administration as being service-connected. In these cases the veteran will usually be able to furnish a VA Form P-80a, "Award of Disability Compensation or Pension". This form will state the condition for which the veteran is service-connected.

2. To veterans who are in training under Public Law 16, where treatment for any condition is necessary to avoid interruption of such training.

3. To veterans seeking treatment for conditions which may be presumed to have occurred in service, or to have been aggravated by the service, such as malaria, filariasis, tropical fever, gun-shot wounds, etc.

4. For conditions where a definite statement is made by the veteran that the illness started in service or that he was treated in service, or began so soon after service that it must have originated before discharge.

PREPARATION OF THE FORMS

General rules to be followed by the physician in rendering out-patient treatment to eligible veterans are these:

1. Completely fill out the VA Form MD-1, "Request for Authority for Out-Patient Treatment". A few of the more important points to be noted in filling out this form are the following:

Section (1)—Accurate information as to the veteran's service and discharge. Information should be obtained from veteran's discharge certificate.

Section (4)—Be sure to state whether the condition is or is not medically emergent.

Section (6)—If hospitalization is recommended a VA Form P-10, "Application for Hospital Treatment or Domiciliary Care", should accompany the request. These forms can be obtained at any Veterans Administration Office or at the office of any service organization.

Section (7)—If treatment was rendered for which authorization is desired, state the date and type of treatment rendered.

Section (8)—If additional treatments are necessary it is essential that you indicate the number of treatments and specify the month in which they will be rendered. Authorizations for out-patient treatment are only *valid for the month specified.* If it is impossible to determine the exact number of treatments, give an approximate number, keeping in mind that if you use less than requested, bill us for less. If you require more, a VA Form MD-2, "Request for Continued Treatment", will accompany the original authorization and can be sent in for the additional number of treatments required. Filling the form out and noting in this section "indefinite" or "?" only holds up the issuance of the authorization.

Section (10)—If additional services, such as x-ray, laboratory, consultation, etc., are requested, the service should be clearly noted; and if other than the treating physician will perform the service, the full name and address should be shown, so that authorization can be correctly issued.

Section (11)—Print your name and address clearly. Many delays are due to our inability to determine the name of the requesting physician.

Section (12)—Accredited specialists should so indicate, in order that the correct fees can be authorized.

2. The VA Form MD-1, "Request for Authority for Out-Patient Treatment", together with the veteran's application, VA Form PH 10-27, "Application for Out-Patient Treat-

ment", must be mailed within five days of the date initial treatment is rendered, to the Veterans Administration, 20 Washington Place, Newark, New Jersey. Authorization cannot be issued unless requested within the allowed period—five days.

3. Treatments requested may begin as soon as the forms are mailed. It is not necessary to await actual receipt of the authorizations. Current workloads may delay issuance of the authorizations for a few days. However, it is understood that if the veteran is not eligible the treatments rendered become a matter between the veteran and his physician.

4. "Report of Treatment Rendered", VA Form 2690a, must be submitted each month. This form no longer has to be signed by the veteran.

5. Medications are supplied to the veteran by mail from the Veterans Administration upon receipt of the prescription from the physician, or under the plan described below.

DRUGS AND SUPPLIES FOR VETERANS

Veterans receiving care from physicians under our Veterans Care Plan may also obtain without cost all necessary medications and a limited list of medical supplies provided the physician issues a prescription for the drug or supply in duplicate. The extra copy of the Rx is necessary because the pharmacist must keep one in his own files and forward the other to the VA for reimbursement. To be valid the prescription blank must bear date, name and address of patient and just above the physician's signature, the sentence: *I am authorized to treat and prescribe for the above named Veteran's Administration patient.* If there is no room for this certificate on the face of the Rx blank, it may be written and signed on the reverse side. The Veteran should be advised to make sure that the pharmacist he selects is authorized to fill such prescriptions and that he goes there within ten days of his visit to the physician. Only members of the N. J. Pharmaceutical Association are eligible for reimbursement under this plan. The supplies listed below are also available without cost to the veteran on the same basis as drugs, and the physician must request the item on his regular Rx blank, written in duplicate, and bearing the certificate italicized above. Authorized medical requisites which the local pharmacist may supply are limited to the following items:

Insulin syringe	Ulcer syringe
Two hypo needles	Feeding tube
Atomizer	Enema can
Nebulizer	Bed pan
Hot water bottle	Urinal
Fountain syringe	Ice cap
Ear syringe	Ice bag
Medications	Drugs

For further information on this plan and for a list of local pharmacies authorized to fill these prescriptions, write to the Secretary, N. J. Pharmaceutical Association, room 319, at 28 West State Street, Trenton 8, N. J.

PURCHASE OF ARMY-NAVY SURPLUS MEDICAL EQUIPMENT

Physician-veterans now enjoy a number 2 priority in the purchase of army-navy surplus medical equipment. Only the federal government has an earlier chance to buy such equipment. To take advantage of this, the physician-veteran will go to the nearest *War Assets Administration* office, show evidence of his veteran status, submit a list of his wants, and pick up a certificate. Officials at the War Assets office will advise as to the next step. The War Assets Administration offices in and near New Jersey are as follows:

Newark—309 Washington Street
Trenton—143 East State Street, Room 622
New York City—37 Broadway; also 350 Fifth Avenue
Philadelphia—1612 Market Street; also 1528 Walnut Street

DELETIONS FROM THE PHARMACOPEIA

The following items, official in the U. S. P. XII, have been deleted and will not be included in the new Pharmacopeia (US.P. XIII) which will appear this fall:

Acetonum
Acidum aceticum
Acidum aminoaceticum
Acidum lacticum
Acidum mandelicum
Acidum nitricum
Acidum phosphoricum
Acidum phosphoricum dilutum
Acidum sulfuricum
Acidum sulfuricum dilutum
Aethylis chaulmoogras
Alcohol dehydratum
Allylis isothiocyanas
Althaea
Antipyrina
Aqua chloroformi
Argentum proteinicum forte
Belladonnae radix
Bismuthi subnitras
Calcii phosphas tribasicus
Capsulae carbonei tetrachloridi
Capsulae olei chenopodii
Capsulae triasyni B cum hepati
Carbonei tetrachloridum
Ceratum
Ceratum resinae
Chloramina—T
Codeina
Colchici semen
Concentratum B-Vitaminarum hepatis
Dscocta
Emplastrum belladonnae
Emulsum olei terebinthinae
Ergota
Eriodictyon
Eucainae hydrochloridum
Extractum hyoscyami
Extractum malti
Extractum rhei
Fel bovis
Ferri et ammonii citrates virides
Ferrum reductum
Fluidextractum ergotae
Fluidextractum eriodictyi
Hydrargyri bichloridum
Hydrargyri salicylas
Hydrargyri succinimidum
Hydrargyrum cum creta
Infusa
Injectio B-vitaminarum hepatis
Injectio hydrargyri salicylatis
Injectio strophanthini
Injectio triasyni B cum hepati
Linum
Liquor acidi arseniosi
Liquor hydrogenii peroxidi fortior
Liquor iodi
Lycopodium
Magnesii phosphas tribasicus
Massa ferri carbonatis
Mel
Nux vomica
Oleum amygdalae amarae
Oleum chaulmoograe
Oleum chenopodii
Oleum juniperi
Oleum lini
Oleum Picis Rectificatum
Oleum pini pumilionis
Oleum terebinthinae
Oleum terebinthinae rectificatum
Pamaquinae maphthoas
Pelletierinae tannas
Phenylis salicylas
Pilulae ferri carbonatis
Potassa sulfurata
Potassii bitartras
Potassii nitras
Pulvis cretae compositus
Quininae aethylcarbonas
Quininae et ureae hydrochloridum
Resina
Serum antimeningococcicum
Serum antipneumococcicum
Serum immune morbillosi humanum
Serum immune scarlatinae humanum
Sevum praeparatum
Sodii cacodylas
Spiritus anisi
Spiritus camphorae
Spiritus frumenti
Spiritus glycerylis trinitratis
Spiritus vini vitis
Strophanthinum
Sulfapyridinum
Sulfapyridinum sodicum sterile
Syrupus picis pini
Tabellae magnesii phosphatis tribasici
Tabellae sulfapyridini
Terpini hydras
Thymolis iodidum
Tinctura colchici seminis
Tinctura iodi (7 per cent)*
Tinctura nucis vomicae
Toxitabellae hydrargyri bichloridi magnae
Toxitabellae hydrargyri bichloridi parvae
Trinitrophenol
Unguentum iodi
Zinci acetas
Zinci chloridum

* The title "Iodine tincture" is retained in the U.S.P. XIII but it now applies to mild iodine tincture (2 per cent) of the U.S.P. XII.

NUTRITION IN EVERYDAY PRACTICE

SYMPOSIUM ON DIABETES

S. WILLIAM KALB, M.D., Newark, N. J.
Chairman Nutrition Committee

These questions and answers are from the panel discussion of the Council of the American Diabetes Association at the proceedings of the Association in New York January 13. Dr. Edward Tolston presided.

1. *In diabetic coma, should insulin be administered intravenously or subcutaneously?*

DR. WOODYATT: I can't give any specific data on that. Routinely I depend on subcutaneous injection. In the early days when we compared the two methods of administration, we didn't find any definite advantage in the intravenous method.

DR. BEST: I can speak only as a physiologist. If I had my way, I would give it intravenously as then you are sure that it will be absorbed completely.

DR. WILDER: When making a salt solution with glucose, we frequently add the insulin to what is running through the veins, so often it is given in the vein. If the circulatory picture is very severe, one would turn to the intravenous route; we do so frequently.

DR. ROOT: There is a small group of patients with extraordinary subcutaneous atrophy. When insulin was given into the vein, we could obtain a fall in the blood sugar.

2. *Is the obese mild diabetic difficult to control? Should such patients be given insulin or should they be permitted to be glycosuric?*

DR. JOSLIN: Neither. I should send such patients to the minister to learn moral control. We followed a diabetic nun for several years who weighed 259 pounds and had a high blood pressure. In order to profit by a sympathectomy, Dr. Poppen insisted on preliminary weight reduction. She was then operated upon with success, her blood pressure fell from over 250 to 125, her insulin dropped from 64 to 8 units while her weight changed from 257 to 197 pounds.

DR. BARACH: I saw a movie last night called the *Keys to the Kingdom,* and the priest's advice to an obese woman was "Get thin; the gates of heaven are narrow." In practice I am perfectly willing to go along on a minimum diet without insulin.

3. *What is the maximum dose of regular insulin that can be given at one time? Will 100 units be utilized or wasted?*

DR. BEST: I am sure that no one here would attempt to answer this question. Some would be excreted and wasted. Less effect is secured with high dosages. You have to square the dosage and not double it when you get up to high amounts.

DR. BEARDWOOD: Somebody who asked Abe Lincoln about the length of his legs got the answer that they were long enough to reach the ground. The dose of insulin should be sufficient to control the blood sugar. You don't get twice as much reduction of the blood sugar from twice as much insulin. When we first begin work on a patient we start out with 30 to 35 units. On the other hand, Snader has followed a patient who for ten months took an average of 1600 units a day and reducing his regular insulin to any great extent resulted in increasing his blood sugar. It is a question of what you want to do.

4. *What is the basis for loss of knee jerks in a diabetic of ten years standing?*

DR. ROOT: We assume that it is an effect of the diabetes on the nervous system, mainly in the central nervous system, the cord.

DR. WOODYATT: In the majority of loss of knee jerks in elderly people, it is associated with peripheral multiple neuritis.

5. *What is the explanation for the cause of death in diabetic coma with no evidence of peripheral failure?*

DR. MIRSKY: If the patient has been in coma long enough changes occur in the central nervous system. We have a syndrome like traumatic shock.

DR. DILLON: Years ago our mortality at Philadelphia General Hospital was excessive. In one case after another a man's chemistry fell, but after being treated for 12 to 18 hours, he proceeded to die in spite of treatment. In those studies we found that there were certain damages in the brain which we believe to have been the cause of death.

DR. STRIKER: I think there are two points that should be stressed when we talk about normal blood chemistry. One is that many of us forget to include nitrogen studies. Kidney damage should be considered. The second point is the use of fluids—normal salt solution; in several instances such hydration was caused that the patient really drowned in his own fluids.

6. *Is it preferable to have high blood sugar in coronary diseases and coronary insufficiency?*

DR. JOSLIN: It is preferable to have a high blood sugar rather than a low one in coronary insufficiency. Coronary cases can be treated with insulin to great advantage, but one is never careless, and even an approaching hypoglycemia is avoided. What these old arteriosclerotics will tolerate is past belief. A man who had had three cerebral accidents went into diabetic coma. During convalescence, at one time by error, his blood sugar fell to 29 milligrams. However, he suffered no ill effects. With regard to diabetic coma: not a word has been said tonight about alkalies; so we are progressing. Insulin should be given and is paramount in treatment. Our series of 603 coma cases since 1923 shows that in the first 50 cases we had 18 per cent mortality and these patients received 83 units in the first three hours; the last 50 cases received 216 units in the same space of time and the mortality was 1.4 per cent. The chief point in the treatment of diabetic coma is to give insulin early and enough of it so that advanced coma never has a chance to develop.

ASSOCIATES AVAILABLE

The following New Jersey physicians are available for association as indicated. If interested in establishing contact with any of these doctors, write to The Medical Society at 315 West State Street, Trenton 8, New Jersey. Indicate whether you are referring to notice 8, notice 9, notice 10, etc.

7. GENERAL PRACTITIONER, veteran, age 48, licensed in N. Y. and N. J., desires placement as office assistant or associate with physician in any specialty. Paterson, Hawthorne, Clifton area preferred.

8. GENERAL PRACTITIONER, veteran, age 34, who has had residency in neuropsychiatry, licensed in both N. Y. and N. J., interested in becoming associated with a group as general practitioner or as neuropsychiatrist preferably in northern New Jersey.

9. INTERNIST, veteran, age 39, army classification as gastro-enterologist and internist, desires to locate in Paterson or northern New Jersey area, interested in association if practice can be limited to internal medicine.

10. GENERAL PRACTITIONER desires association in a medium sized community preferably near Paterson.

11. GENERAL PRACTITIONER, age 27, desires to associate himself with a general practitioner or internist anywhere in New Jersey.

12. SURGEON, veteran, age 31, army experience in orthopedics, battle casualty surgery, proctology and general surgery, interested in associating himself with surgeon or with general practitioner who does fair amount of surgery; especially interested in proctology and in general surgery. Prefers northern New Jersey.

13. ANESTHETIST and SURGEON, age 30, veteran, holds N. J. and Penna. licenses, desires assistantship in industrial surgery, anesthesia or general surgery, Prefers Camden County or Morris County area.

14. GENERAL PRACTITIONER desires association, preferably in an industrial area; age 28, former army battalion surgeon. Any opportunity and any part of New Jersey will be considered.

15. RADIOLOGIST, eligible for American Boards, fully trained in both diagnostic radiology and radiation therapy, desires association with certified radiologist in office or hospital, part time or full time, preferably in Northern New Jersey.

16. MATURE GENERAL PRACTITIONER available as part-time associate for internist, dermatologist or obstetrician in northern New Jersey.

17. WELL TRAINED INTERNIST now completing residency, qualified for Boards, available next June for association with general practitioner or specialist in any part of state.

18. DERMATOLOGIST, BOARD DIPLOMATE; age 46; had 3 years as chief of dermatology in large Army hospital; now wants association with established dermatologist in any part of New Jersey.

A physician licensed in N. J. interested in (a) finding an office associate or (b) securing placement as an office associate may send a brief notice to that effect, listing essential details, to Executive Offices, Medical Society of N. J., at 315 West State Street, Trenton 8, N. J. There will be no charge for publication, but these notices will not be used to advertise practices, offices or equipment for purchase or sale. This free service is available to individual physicians only and not to companies or business organizations. September 20 is deadline for October notices.

TUMOR SYMPOSIUM IN NEW YORK

An advanced course in tumors features the graduate fortnight of the New York Academy of Medicine this year. The fortnight begins on October 7 and ends on October 18. *Mornings* will be devoted to panel discussions and doctors who register for the fortnight (registration fee for the entire program is $5) are welcome to submit questions to the panels in advance. Subjects for the panel discussions (11 a. m. at the Academy, 2 East 103d St.) are:

Oct. 8—Tumors of the female generative tract.
Oct. 11—Tumors of the gastro-intestinal tract.
Oct. 15—Tumors of the lymphatic system.
Oct. 18—Tumors of the male genito-urinary tract.

Afternoons are available for special clinics held from 2 to 5 p. m. as follows:

Oct. 7—Lenox Hill and Roosevelt Hospitals
Oct. 8—Flower and St. Luke's Hospitals
Oct. 9—Presbyterian Hospital and Neurological Institute
Oct. 10—Morrisania Hospital and The New York Hospital
Oct. 11—Woman's Hospital, Veterans Hospital and the N. Y. City Cancer Institute
Oct. 14—Hospital for Joint Diseases and the Memorial Hospital
Oct. 15—Bellevue and Beth Israel Hospitals
Oct. 16—Montefiore and St. Vincent's Hospitals
Oct. 17—Mt. Sinai Hospital and the Hospital for Special Surgery
Oct. 18—Postgraduate Hospital and Polyclinic Hospital

Evenings will be devoted to a series of lectures at the Academy, 2 East 103d Street, New York. These lectures begin at 8:30 p. m.

Oct. 7—Recent advances in cancer research and therapy.
Oct. 8—Tumors of the nervous system and thyroid gland.
Oct. 9—Tumors of the male genito-urinary tract.
Oct. 10—Tumors of the lung and lymphatic system, including leukemia.
Oct. 11—Tumors of the gastro-intestinal tract.
Oct. 14—Tumors of the uterus and breast.
Oct. 15—Tumors of the skeletal system.
Oct. 16—Tumors of the skin, including occupational and posttraumatic cancer.
Oct. 17—Tumors of the mouth, eye, ear, and throat.
Oct. 18—Early diagnosis and prophylaxis of cancer.

Registration and further information from Graduate Fortnight Committee, Academy of Medicine, 2 East 103d St., New York City.

COUNTY MEDICAL SOCIETIES OF NEW JERSEY

DATES OF MEETINGS, SEPTEMBER, 1946 - JULY, 1947

County	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June	July
Atlantic	13	11	8	13	10	14	14	11	**9**	..	..
Bergen	10	8	12	10	14	11	11	8	**13**	10	..
Burlington	12	10	14	12	9	13	13	10	**8**	..	..
Camden	..	1	5	3	7	4	4	1	**6**	..	..
Cape May	..	22	26	27	28	25	25	22	**27**	..	..
Cumberland	..	8	*	10	*	11	*	**8**	*	10	..
Essex	..	10	14	*	9	13	13	10	**8**	..	..
Gloucester	19	17	21	19	16	20	20	17	**15**	..	..
Hudson	..	1	5	3	7	4	4	1	**6**	..	..
Hunterdon	..	22	..	..	28	..	..	**22**	..	..	22
Mercer	..	9	13	**11**	8	12	12	9	14	11	..
Middlesex	..	16	20	**18**	15	19	19	16	21	18	..
Monmouth	25	23	27	18	22	26	26	**23**	28	25	..
Morris	..	17	..	19	..	..	20	..	..	**19**	..
Ocean	11	9	13	11	8	12	12	9	**14**	11	..
Passaic	17	15	19	17	21	18	18	15	**20**	..	..
Salem	20	18	15	20	17	21	21	18	**16**	..	..
Somerset	..	10	14	12	9	13	13	10	8	**12**	..
Sussex	*	..	..	*	..	*	..	..	*	..	..
Union	11	..	13	..	8	..	12	**9**	14	..	..
Warren	..	**15**	..	..	21	..	..	15	..	..	15

* Meets in this month at call of president.
Boldface dates indicate annual meeting.

UNOFFICIAL MEDICAL GROUPS

EXCERPTS FROM AN ADDRESS ON THE PUBLIC RELATIONS OF AMERICAN MEDICINE DELIVERED FEB. 8, 1946, BY DR. MORRIS FISHBEIN

Among the membership of the American Medical Association is a small percentage of physicians who do not agree with the policies of the House of Delegates regarding social aspects of the practice of medicine. Such groups as the Physicians Forum, the Committee of Physicians and the American Association of Physicians and Surgeons from time to time express themeselves on such subjects. They compete through press releases, radio talks and in various other ways for public support with the official agencies of American medicine.

THE PHYSICIANS FORUM

The Physicians Forum includes in its membership something under 2,000 names with perhaps 50 active participants in its work. This is purely an estimate although it is based on communications which have been received from Dr. Ernst Boas who spearheads this effort in favor of socialized medicine.

THE COMMITTEE OF PHYSICIANS

The Committee of Physicians once included some 400 names and may now include something under 1,000. Its active body includes not more than fifteen and probably two—namely, John Peters and Allen Butler who do 99 per cent of its work and make its opinions.

THE A. A. P. S.

The American Association of Physicians and Surgeons has, according to fairly well substantiated rumor, received $10 from each of 6,000 physicians who have subscribed to its principles. Just what it has accomplished other than to state its objectives and to get them out in the press is not clearly apparent. This group, however, proposes that the physicians of the United States strike against the sick public in case the government of the United States should establish compulsory sickness insurance. Such an action would be contrary to all of the tradition of medical science covering the responsibility of the physician to the sick. No official body of the American Medical Association has ever ventured even the thought that physicians would neglect to minister to the sick as evidence of their opposition to any law.

THE NATIONAL PHYSICIANS COMMITTEE

The National Physicians Committee has been most effective of all of the organizations striving to mold public and legislative opinion in the field of medical care. Its efforts have been repeatedly endorsed by the House of Delegates of the American Medical Association. This agency has used syndicated newspaper publicity and editorial opinion, newspaper advertising, pamphlets, radio, direct-by-mail solicitation, education and every other technic of public relations in its work.

Currently some thousands of representatives of medical industries are encouraging everyone whom they meet or interview to communicate directly with the Congress expressing opposition to the compulsory sickness insurance feature of the National Health Program and to the Wagner-Murray-Dingell bill.

In many communities joint action by physicians and medical industries has been stimulated by the insertion of advertising in the press, the use of local radio and other public relations work against state medicine. From twelve to fifteen million pamphlets were circulated in the attack on the previous Wagner-Murray-Dingell bill which passed into innocuous desuetude, and many millions of pamphlets are now being circulated through drug stores, supply houses, hospitals and other medical agencies.

Through this group also physicians are being educated as to the details of the proposed legislation and they will be encouraged to make direct contact with legislators from their own states to make certain that the legislators are fully informed. The budget approximates several hundreds of thousands of dollars and the funds are, as nearly as I can determine, efficiently and economically used.

RESOLUTION OF THE HOUSE OF DELEGATES OF THE AMERICAN MEDICAL ASSOCIATION

Whereas, The members of this House of Delegates as well as physicians throughout the United States are cognizant of the increasingly effective work of the National Physicians Committee for the Extension of Medical Service in familiarizing the public with the values, methods and achievements of American medicine; therefore,

Be It Resolved that we reaffirm our approval of the National Physicians Committee and commend the Board of Trustees and the Management of this institution for the effectiveness of their efforts.

OBITUARIES

DR. CARL BISHOP

Dr. Carl Bishop died in Christiansburg, Virginia, on July 27, 1946, at the age of 48.

Dr. Bishop came to Plainfield to enter the practice of eye, ear, nose and throat in 1925. He quickly established his reputation as an expert in his chosen field and was beloved by his patients and respected by his fellow physicians. He was a Fellow of the American College of Surgeons and was certified by the American Board of Otolaryngology in 1929. He has been Senior Surgeon of the Eye, Ear, Nose and Throat Department of the Muhlenberg Hospital since 1928 and a faithful member of the Union County Medical Society since 1926.

Although handicapped by prolonged illness, he neglected his own health to devote his energies to the welfare of his patients. By almost superhuman effort he was able to keep his professional skill at its former high level of perfection. His many loyal patients will keenly feel the loss of this kindly spirit and expert care.

DR. LAWRENCE H. BLOOM

Dr. Lawrence H. Bloom of Easton and Philipsburg died at the age of 52 on August 5, 1946. Though a member of the Northampton (Penna.) County Medical Society, Dr. Bloom was active in Warren County (N. J.) medical affairs and was on the staff of the Warren Hospital in Phillipsburg. He was graduated from the University of Maryland Medical School in 1917. The staff of the Warren County Hospital has adopted the following resolution:

Whereas, It has pleased Almighty God in His infinite wisdom to remove from our midst our esteemed and beloved fellow practitioner, Dr. Lawrence H. Bloom, we the members of the staff of Warren Hospital and the Warren County Medical Society desire to express our feelings in the following resolutions:

Be It Resolved, That in the loss of Dr. Bloom the medical profession of Warren County and the town of Phillipsburg have lost a loyal friend, a sympathetic counsellor, a man of great integrity and beauty of character, and also one of unusual medical ability whose ideals and ethics were on the highest level.

Be It Also Resolved, That the community in which he worked and lived and where he has practiced medicine for many years, giving unstintingly of his time, strength and talents, has suffered an irreparable loss. Whenever his services were desired, night or day, by rich or poor, they were cheerfully given; his first thought being the welfare of his patient.

Be It Also Further Resolved, That the members of the staff, and the Warren County Medical Society extend their heartfelt sympathy to the bereaved family in their great loss and that these resolutions be spread on the minutes of the staff, and the society and that a copy be sent to The Medical Society of New Jersey as well as to the family.

DR. HARRY R. NORTH

Dr. Harry R. North, one of Trenton's leading otolaryngologists and one of The Medical Society of New Jersey's senior trustees, died at his home on August 5 at the age of 68. Born in Maine in 1878, he came to Philadelphia for his medical education and was graduated from the Jefferson Medical College in 1904. He elected to remain in this part of the country and opened his office in Trenton the following year. He became interested in otolaryngology and served in that specialty at the St. Francis Hospital in Trenton, becoming chief of the department in 1916. He was active in the affairs of the Mercer County Medical Society, which he served as treasurer for a period of almost thirty years. In 1926 he was elected to the Board of Trustees of The Medical Society of New Jersey and the following year became chairman of the Finance and Budget Committee. He was re-elected to that post every year since and was in active service as Finance and Budget Chairman at the time of his death. Editorial comment on the Society's loss appears on page 357 of this issue of the JOURNAL.

DR. BENJAMIN RUBIN

While on active military duty, Dr. Benjamin Rubin of South River, N. J., died at the Walter Reed Hospital in Washington, D. C., on July 29, 1946. Colonel Rubin was only 42 at the time of his death. A graduate of Syracuse University, class of 1925, he served as instructor in chemistry at Columbia University for three years, and then matriculated at the medical college of Edinburgh University (Scotland) receiving the M.D. degree in 1932. After an internship in Jersey City, he was awarded a fellowship and residency at Mt. Sinai Hospital, New York, and at the conclusion of his project there, he came to South River in 1938 for private practice, specializing in internal medicine. He was on the staff of St. Peter's Hospital in New Brunswick and the General Hospital in Perth Amboy. He was commissioned a major in the Army of the United States in 1942, and after a distinguished career in the European Theatre (he was chief of the medical service at the 203d General Hospital) he was promoted to lieutenant colonel and returned to the U. S. A. to serve as chief of the medical service at the Birmingham General Hospital in Van Nuys, California. He served in that capacity until November, 1945, when by reason of illness he was sent as a patient to the Walter Reed General Hospital where he died last month.

THE BULLETIN BOARD

An Academy of Occupational Medicine has been formed to study and implement methods of improving the health of the worker and methods of disseminating knowledge of the causes, diagnosis, evaluation, prevention and treatment of occupational disorders. For further information write to the secretary of the Academy, Dr. James M. Carlisle, Medical Department, Merck and Company, Rahway, N. J.

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Physicians with an interest in, or aptitude for, nonmedical writing are reminded of the Physicians Literary Guild which was organized recently to encourage extracurricular writing by doctors. A special volume of stories and articles by physicians is being planned for the centenary meeting of the A. M. A. Doctors who wish to submit manuscripts for this book or learn more about the guild may obtain full information from Dr. Francis H. Redewill, Flood Building, San Francisco.

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An international diabetes clinic is announced for September 23 in Indianapolis. Heading an array of world famous authorities will be Professor Best, co-discoverer of insulin. Dr. E. J. Joslin of Boston, Dr. H. C. Hagedorn of Denmark, and Professor B. A. Houssay of Buenos Aires are also listed among the speakers. The program is sponsored by the Eli Lilly Company of Indianapolis who will furnish a detailed program on request.

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Obstetricians and gynecologists are reminded that November 1 is the deadline for filing applications for the next examination of the American Board in that specialty. Applications and further information may be obtained from Dr. Paul Titus, room 1015, Highland Building, Pittsburgh 6, Penna.

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The National Industrial Health Congress will meet in Boston this year at the Copley Plaza Hotel during the week of September 30. Symposiums on lead poisoning, industrial physiology, workmen's compensation and aviation medicine will highlight the program. More complete information is obtainable from Mr. John E. Farrell, 106 Francis St., Providence 3, R. I.

American Public Health Association meets this year in Cleveland, Ohio, during the week beginning November 11. To obtain full program write to American Public Health Association, 1790 Broadway, New York City 19.

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Physicians who have contact with courts of law will be interested in a Master Index giving citations to more than 100 studies on medicolegal problems. This pamphlet may be obtained from Professor Hubert Winston Smith, 310 Altgeld Hall, University of Illinois, Urbana, Ill., by sending twenty cents in stamps.

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Three new volumes in Schuman's Library of Medical History have just been released. These are *New Aspects of John and William Hunter* ($6.00), *William Beaumont's Formative Years* ($6.00), and the *Reception of William Beaumont's Discovery in Europe* ($5.00). These volumes are available from the publisher at 20 East 70th Street, New York 21.

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Dermatologists and syphilologists are promised complete review coverage of their specialties in the new *Quarterly Review of Dermatology and Syphilology* just announced by the Washington Institute of Medicine. Donald Pillsbury, M.D., has been named editor-in-chief.

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A compact 17-page atlas of the structures of the human head is now available at a price of one dollar. Called *Transvision Anatomy,* the book shows the muscles, nerve distribution, blood supply and other structures of the oral cavity by means of "transvisional" transparencies. Copies are sold by the Wernet Dental Manufacturing Company, 190 Baldwin Avenue, Jersey City, N. J.

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Have you obtained your pocket-sized *Physicians Handbook of Reports Required by Law?* It's a pamphlet packed with the facts that every physician should know . . . must know, indeed, to comply with the state's health laws. To get your copy, write to Department of Health, Trenton 7, N. J., and ask for Circular Number 192.

WOMAN'S AUXILIARY

PRESIDENT'S MESSAGE

MRS. FREDERICK G. WANDALL

As we look around the world, we are struck by the fact that the happy people are the ones who are doing the world's work. No matter how trivial the task, there is joy in work well done. In becoming a member of the Auxiliary to The Medical Society of New Jersey, we automatically pledge ourselves to "Interpret the aims of the medical profession to other organizations interested in the promotion of health education", to "Encourage friendliness among families of the medical profession" and "To assist in the entertainment at annual sessions of The Medical Society". Are these tasks not worthy of the talents, capabilities, and innate interests of the wives of the men who have pledged themselves to fight disease and further the science of medicine?

Our Auxiliary has grown in its responsibilities to The Medical Society as the problems in the society have grown. The trend towards government control has invaded the sacred practice of medicine, and we must go hand in hand with our husbands in preventing any kind of legislation that would harm the relationship of physician to patient. The termination of war did not bring a clear-cut victory to the United States. The avowed objective of freedom from political oppression for which the war was fought is less in evidence today than at any previous time. The months behind us and the months ahead will be most trying times on the strength and resources of the practicing physician in history. We as an Auxiliary can do much to enlighten the public through our public relations program. The Woman's Auxiliary must take the lead in medical peace programs, rather than spend their efforts in conjunction with other organizations, and thus dissipate their force as a medical group. I do not imply that we should not cooperate, but it is clear that the Auxiliary will need to be a channel through which medical education must flow.

In our Auxiliary there is but one way we can progress. We must have a common understanding. There must be team work, and a oneness of purpose, if we expect to serve The Medical Society constructively. We must be organized over the entire state. Numerical growth is essential to the life of any organization. In this way, new blood, new ideas and new interest will flow through our Auxiliary.

Therefore let us stand together in the true spirit of our Auxiliary, that we may be proud that we are members of The Woman's Auxiliary to The Medical Society of New Jersey, and the world will know us for what we are.

PRESS AND PUBLICITY

First rule of procedure in writing press releases, reports, or any other articles to be sent to the Chairman of Publicity or to the Editorial Office in Trenton is this: they must be typed double spaced. No reports for the JOURNAL should be submitted in any other form. Reports and advance notices for the JOURNAL must be in the hands of the State Chairman of Publicity by the 18th of each month. Advance notices handed in on the 18th should be those which are to take place after the 15th of the following month. Unless the meeting of the Auxiliary is of such standard as to warrant the presence of a newspaper reporter, the County Chairman of Publicity should send immediately following each meeting a concise resume of events to the leading newspapers of her county. Advance notices of these meetings should be sent to the same papers a week preceding the meeting.

All notices pertaining to Auxiliary activity should be clipped and forwarded to the State Chairman of Publicity with the monthly reports. Reports of the Auxiliary activities should likewise be sent to the official publication of the County Medical Society.

It is the duty of each County Chairman of Publicity to work at all times to increase the prestige of her Auxiliary in the community.

MRS. THEODORE ROBIE,
130 Bellevue Avenue,
Upper Montclair.

BOOK REVIEWS

Diseases of the Retina. By Herman Elwyn, M.D. Pp. 587 with 170 illustrations. Philadelphia, 1946, Blakiston. $10.

Although ophthalmologic writing has been prolific during the last three decades, few texts have concentrated on the retina. This book does not discuss routine ophthalmology nor the normal fundus, but it is a handy volume for the general practitioner. Certainly the internist will find much to help him. Naturally it will be of major interest to the ophthalmologist who will find here a well-organized, comprehensive and highly readable book which will serve both as a practical guide and a work of reference. Irvin Levy, M.D.

Management of Obstetric Difficulties. By Paul Titus, M.D., ed. Pp. 1000 with 426 illustrations. St. Louis, 1946, C. V. Mosby Co. $10.00.

An amazing one-volume encyclopedia is the best characterization for this thoroughly revised edition of the well-known "Titus". The historical references, the reflections on classical medicine and the perfect coverage of fundamentals are admirable; but what is especially worthy of attention is Titus' treatment of the clinical aspects of obstetrics, and of what might be called "minor observations". Exemplary samples of this are: the evaluation of symptoms in the chapter on ectopic pregnancy; the surgical approach to the varied complications; the handling of bladder distension; the material on x-ray pelvimetry; and the author's discussion of the Rh factor. The text is valuable to any physician and of course, doubly so, to those interested in obstetrics. Herbert Steiner, M.D.

Personality Factors in Counseling. By Charles A. Curran, Ph.D. New York, Grune & Stratton, Inc. 1945. $4.00.

Father Curran presents the study of a human personality in the process of growth. In a searching analysis of the twenty interviews of a phonographically recorded counseling experience he shows the gradual unfolding of one man's mind and feelings in passing from a stage of confusion and maladjustment to one of normal adjustment.

This book will be of special interest to those who are technically equipped and trained in this field of study and research. But it will also interest those whose work brings them in contact with personal problems—educators, doctors, nurses, social workers, priests and religious people generally.

It is significant that this research study was undertaken by a Catholic clergyman with psychologic training. The growing interest of the religious field in a scientific approach to personality development is exemplified and demonstrated in this volume which promises to stimulate the thinking and broaden the concepts of all concerned with individual growth. Carolyn Valentine, B.S.

The American Hospital. By E. H. Corwin, Ph.D., Commonwealth Fund, 1946. New York. $1.50. 226 pages.

The country's twelfth largest industry is hospital service. Hospital capital assets now amount to almost six billion dollars. In spite of the enormous size of this "industry" and of the physician's very special stake in it, few practitioners are well oriented to the problem of hospital care. One reason is that the data are widely scattered and, where assembled, usually appear in the form of dreary tables. With the publication of this most recent volume in the New York Academy of Medicine's series, there is now no reason why any alert physician should be ill-informed on this subject. This is a compact, inexpensive, authoritative and, surprisingly enough, highly readable book. It reviews in workmanlike fashion the distribution of hospital facilities, the sources of hospital income, the personnel and employment problems, the facts about equipment and buildings, the nature, use and integration of outpatient clinics, and the structure of the professional services within hospitals. The text glitters with interesting little facts. Many physicians will be surprised to learn that in 1940 all but 29 per cent of the country's hospital beds were in tax-supported institutions, that patients' rooms and wards occupy only a fifth of the floor area of the modern hospital, that the policy of having some patients pay for hospitalization is an American innovation, and a rather modern one, that the larger the hospital the smaller the relative number of unoccupied beds, that throughout the United States one person in ten is admitted to a hospital annually, that fewer than half the hospital executives in the country are physicians, and that admission rates of Blue Cross subscribers are 50 per cent higher than for the population as a whole. Each of these facts (and the book contains a hundred others) is in itself food for thought; each could be the basis of a lively evening's discussion. And in the face of current demands for more government hospitalization, it is interesting to reflect that patients in tax-supported general hospitals (not mental or tuberculosis institutions, but general hospitals) remain twice as long as they do in hospitals under private control. Dr. Corwin has told the story well; in what could easily have been a dry and dull monograph, he has maintained a lively pace and furnished medical thinkers and medical talkers with a quiver-full of intellectual ammunition. Henry A. Davidson, M.D.

New and Nonofficial Remedies, 1946. Pp. 770. Chicago: American Medical Association, 1946. ($1.50.)

New and Nonofficial Remedies is the book in which are listed and described the medicinal preparations which the Council on Pharmacy and Chemistry has found acceptable for the use of physicians. To have a product accepted, the manufacturer must declare its composition, give adequate proof of its therapeutic value and market it with claims which have been found valid by the Council. The present

volume represents a cumulative epitome of the Council's work since its foundation in 1905.

Accepted preparations are grouped in twenty-four classifications ranging from Allergenic Preparations to Vitamins. The monograph for the products set forth the actions, uses and dosage and usually a set of tests and standards. As its name implies, the book is intended to describe preparations which are *not* included in such official publications as the Pharmacopeia and the National Formulary. However, some official articles are listed and described, these being those for which the practicing physician needs concise and authoritative information. In the preface, the Council lists thirty-five official drugs ranging from acetylsalicylic acid to strophanthin, which the Council feels it no longer necessary to consider for inclusion in the book. However, in most cases, a brief monograph on actions, uses and dosage gives information useful to the physician and for the control and advertising of marketed preparations.

Examination of the volume reveals that there have been no extensive or radical revisions of the articles. A few revisions of separate monographs may be mentioned: under chaulmoogra derivatives, the recommended use of chaulmoogra oil is limited to sarcoidosis; the dosage statement for quinacrine hydrochloride (atabrine) has been notably expanded to reflect the war-time experience with the drug. The radically revised monograph on amphetamine (benzedrine) is in harmony with the recent Council report on the use of this drug. The monograph on vitamin B complex now mentions synthetic folic acid, recently made available for investigational use.

There appear to be no spectacularly new accepted preparations. Perhaps the most noteworthy is the casein hydrolysate, amigen, acceptance of which will no doubt be followed by that of many more preparations representing the field of amino acid therapy.

Conscientious physicians will have frequent occasion to thumb through the pages of NNR and the book merits a place on the doctor's desk alongside his prescription pad and the telephone directory.

Reports of the Council on Pharmacy and Chemistry of the American Medical Association. Pp. 122. Chicago: American Medical Association, 1946. ($1.00.)

Originally intended as a repository of its reports on rejection of preparations unacceptable for New and Nonofficial Remedies, this volume in recent years has been composed of reports giving general information to the physician on the status of various therapeutic agents and therapeutic procedures. Most of these articles have previously been published in the J. A. M. A. The present volume emphasizes the educational nature of the Council's work and bears witness to its leadership in the consideration of current therapeutic problems. Thus, the chapter on "Dermatophytosis: Treatment and Prophylaxis", gives a concise estimate of progress in this field and sets up useful standards for the evaluation of fungicidal preparations. The report on "Dangers from the External Use of Sulfonamides" stems from war-time experience with these preparations and issues a warning against over-the-counter sales. The item on Poison Ivy Extracts emphasizes the fact that these preparations are to be used in prevention rather than treatment. The report on Acne Bacillus Vaccine points out that this preparation, in the opinion of most investigators, fails in most cases clinically to arrest or control acne vulgaris. In the section entitled "Status of Passive Immunization and Treatment in Pertussis by the Use of Human Hyperimmune Serum" the status of these preparations was definitely outlined just prior to the acceptance by the Council of a number of commercial preparations.

This volume is of interest to physicians, pharmacists, chemists and pharmaceutical manufacturers, and to all who are interested in the progress of drug therapy.

Peace of Mind. By Joshua L. Liebman. Pp. 203. New York, Simon and Schuster. 1946. $2.50.

Books on "how to do it" continue to pour off the presses. How to win friends, how to collect delinquent accounts, how to become a public speaker, and now, how to achieve peace of mind. This volume attempts to fuse religious insight with psychiatric teaching in order to fashion a formula that will enable the troubled to find peace of mind. It is very well written. Dr. Liebman has considerable skill in finding the happy word and in using the attention-arresting, vivid terminology of modern advertising copy as a vehicle for the transmission of philosophical ideas. The specific instructions boil down to such homilies as: look at yourself . . . don't underestimate your own powers . . . love your neighbor . . . examine your fears rationally and maturely . . . trust your conscience but don't exaggerate trivial "sins" . . . and the like. To those whose peace of mind has been assailed by the loss of a loved one, there is advice to express bereavement honestly, to find some one else partly capable of replacing the deceased and to free yourself from bondage to the physical existence of the lost loved one. The psychologic basis of the book is the work of Freud and the conclusions of the analysts generally. The material on religion is well presented, thought-provoking and rationally written. There is an interesting section on the psychology of agnosticism and atheism. The material on applied psychology, however, is somewhat shop-worn, essentially a catalogue of the hopeful advice given in so many other books on the same subject.

Psychiatrists may find the volume helpful in bibliotherapy—certainly a patient can be asked to read it safely, and a discussion of the reading offers a good springboard for subsequent psychiatric interviews. General practitioners who are sensitive to the psychic aspects of somatic disease, may also find *Peace of Mind* an interesting text, and it may suggest lines of inquiry into the patient's emotional life. And any doctor who is called on to deliver a public talk on some mental hygiene or psychosomatic topic will find this volume a good reservoir of source material. The publisher's hope that "this book may well prove to be a vast influence in American life" is perhaps a trifle oversanguine.

Tuberculosis Abstracts

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XIX **September, 1946** **No. 9**

ALL control of communicable disease begins with notification that the disease is present in a certain person at a given address. Verification of the diagnosis may be needed. Search for contacts must be prompt and complete. Each person capable of infecting others must be so controlled as to be no hazard to the community. In tuberculosis patients, this is accomplished preferably by admission to a tuberculosis hospital. Finally, since tuberculosis is a silent and insidious invader, reliance upon complaint of illness by the patient or diagnosis without X-ray of the chest cannot longer be tolerated.

WHAT PUBLIC HEALTH EXPECTS OF THE PRIVATE PHYSICIAN

It is probable that less than half of the active cases of tuberculosis have been known to the authorities at any time in the past thirty years or are today so known. A recent report of the Minnesota State Board of Health states, "In 1910 there were more than three times as many deaths from tuberculosis as there were reported cases. Tuberculosis is a reportable disease, but it has never been adequately reported."

Thirteen states in 1944 showed a ratio of more than three cases of tuberculosis reported for each death from this disease, within the same year Wisconsin leading with 3.70 cases per death. Yet evidence is abundant that probably between seven and ten cases per annual death from tuberculosis could be discovered and reported if all resources of medicine were used to full advantage.

The citizen may well ask why! Is a requirement of the Board of Health, having the force and effect of a law, to be disregarded with impunity? May I respond to the title of my discussion by saying that the humblest expectation of public health is that physicians recognize tuberculosis prior to the patient's death and report every infected person receiving medical care, whether or not such patients are discharging tubercle bacilli.

Until the practicing physician reports all cases of tuberculosis whether open or closed, positive or negative sputum, to the Division of Health at once on making provisional or suspected diagnosis we of the public health workers in official and voluntary agencies cannot give the community, the family, the fellow workmen, a protection to which they are entitled.

The physician in private practice is not only the sole representative of society licensed to deal responsibly before the law with life and death, but he is the medical conscience of the community. Upon his precise, prompt, wholehearted cooperation, the structure of modern public health depends. If in a mistaken spirit of economic self-protection he opposes publicly adopted policies of disease prevention and control within the framework of sanitary law, he tends to undermine his professional prestige and provides ammunition for those who would challenge the present system of medical practice. Some physicians and even specialists in tuberculosis consider that apparently healed so-called reinfection type tuberculosis is of no concern to public authority and they accept no obligation to report such patients. This is a practice that interferes with both epidemiological and public health services indispensable to the proper functioning of a control system.

Among the factors leading to delay in the reporting of cases of tuberculosis is the physician's inclination to spare the feelings of patient and family by not declaring the diagnosis and then by attempting to care for the patient at home as long as the family pays for his services. I am not at the moment concerned with the ethical weakness of the physician's position in such cases, but solely with the effect upon the origin and spread of the infection in the community.

Home care of the tuberculous is of course possible but except under relatively rare conditions whether for the well-to-do or for the wage-earner, it is a distinctly second-best choice from the point of view of therapy and permits almost inevitable transmission of infection to household contacts. When we recall the high probability of infection of nurses under even rigid hospital discipline and with excellent equipment and management in sanatoriums, we cannot doubt the higher probability of such infection in home care of the tuberculous.

It is well to remind ourselves that the progress in control of tuberculosis has been in spite of incomplete and delayed reporting, in spite of the insidious and silent nature of early pulmonary disease and in spite of the lack of any specific resources for creating immunity or for cure in the chemotherapeutic sense.

We know so much we do not use that there is no excuse for discouragement. The question is one of relative speeds or progress, always with the hope that within our lifetime, our offspring will escape wholly what we know has decimated our predecessors and cruelly handicapped our contemporaries. When my grandparents made their home in New York City in 1838 the death rate from tuberculosis was not less than 300. Our grandchildren are living in the same city where a rate of 45 is current today. We can guarantee freedom of the succeeding generations from tuberculosis if we undertake two programs—one of discovery of pulmonary tuberculous disease and the other of isolation or adequate supervision of persons discharging the tubercle bacillus.

What the public health expects of the private physician is no more and no less than it requires of every other citizen, that is prompt compliance with the law. Popular opinion and medical tradition look to the medical profession with confidence to give accurate diagnosis, humane treatment to the sick and prevent the spread of communicable disease from the sick to the well. The medical profession has exercised the disciplines of education and of ethics among its members. Any failures of standards will be best corrected by the organized local and state medical societies.

King Edward VII of England, when told that tuberculosis was a preventable disease, asked why it had not been prevented. It can be prevented in our time if we use our present resources.

What Public Health Expects of the Private Physician, Haven Emerson, M.D. Minnesota Medicine, January, 1946.

IS TUBERCULOSIS FULLY REPORTED?

The United States Public Health Service has released statistics on the number of cases of tuberculosis reported in relation to the number of deaths by states. The wide variations between states implies either that tuberculosis is much more frequent in some states than in others or that the thoroughness of tuberculosis case reporting varies widely. The evidence suggests that it is the recording of cases of tuberculosis in many parts of this country that is incomplete. Unless this deficiency can be remedied it is almost impossible to evaluate the tuberculosis problem in the United States. Physicians are responsible for reporting all cases of tuberculosis to their local health departments and should see to it that this obligation is fulfilled.

Editorial, Journal of the American Medical Association, February 2, 1946.

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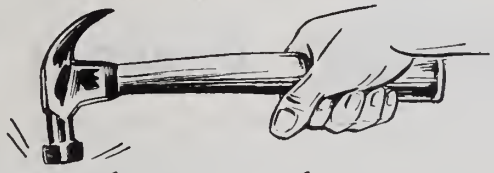
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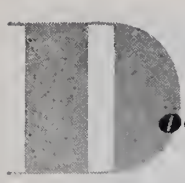
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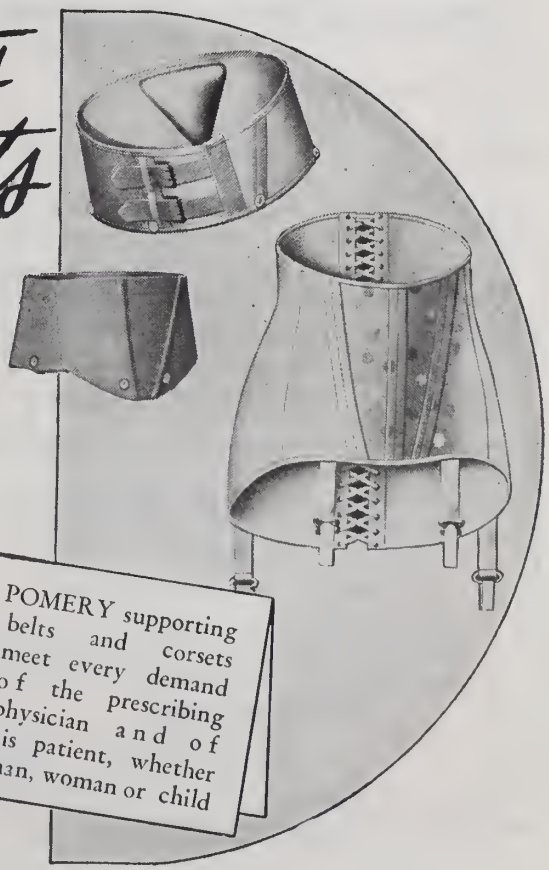
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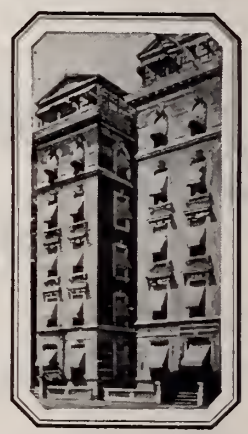


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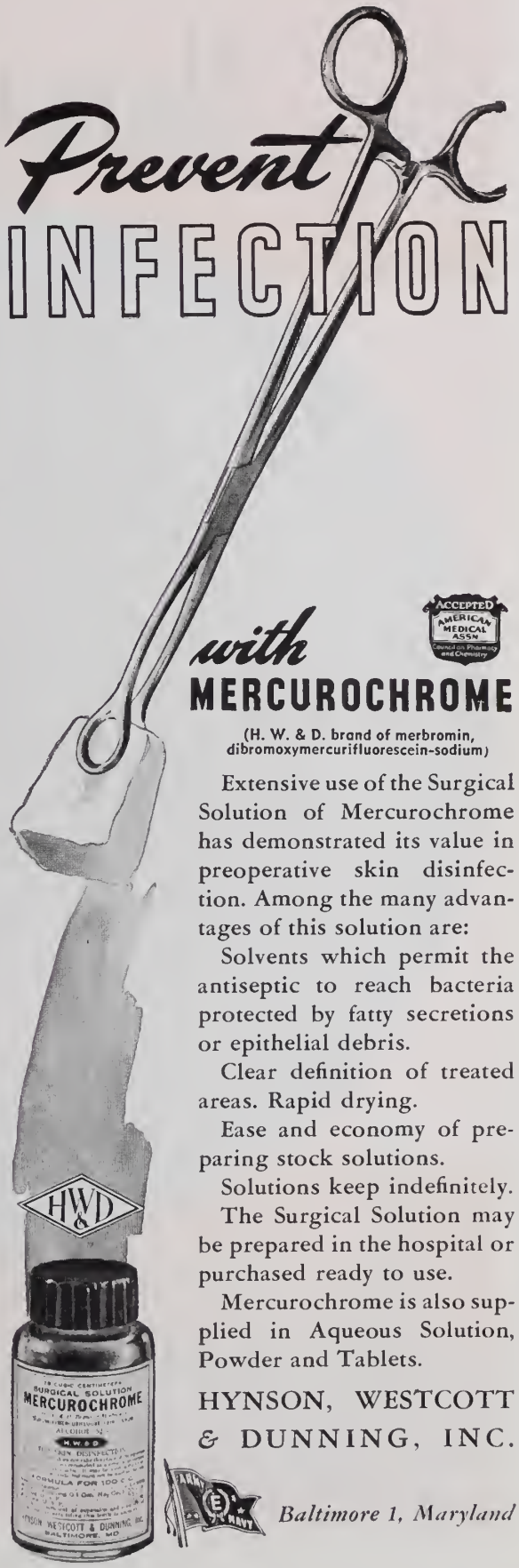
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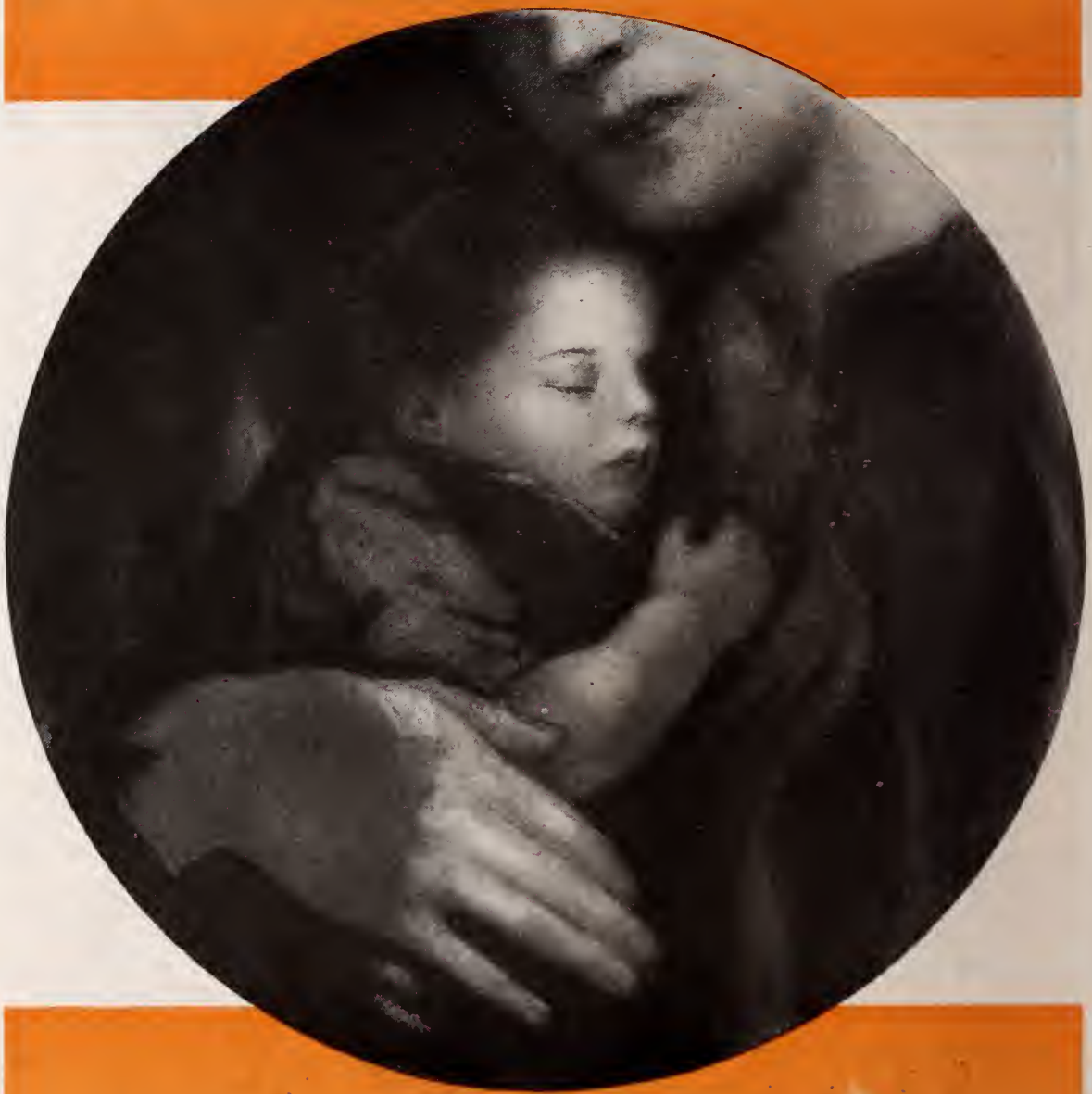
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Place of Publication, Printing and Mailing: 12 South Day St., Orange, N. J.

Editorial and Executive Offices of the Society: 315 West State St., Trenton 8, N. J.

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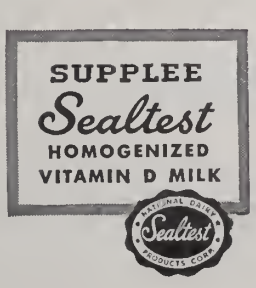
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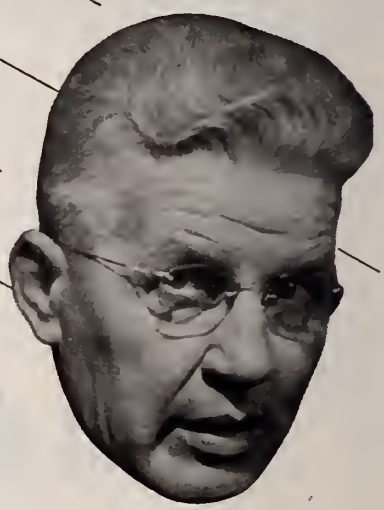


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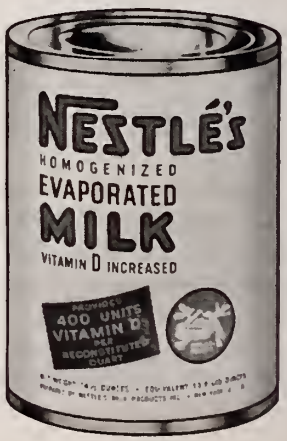
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**Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154.*
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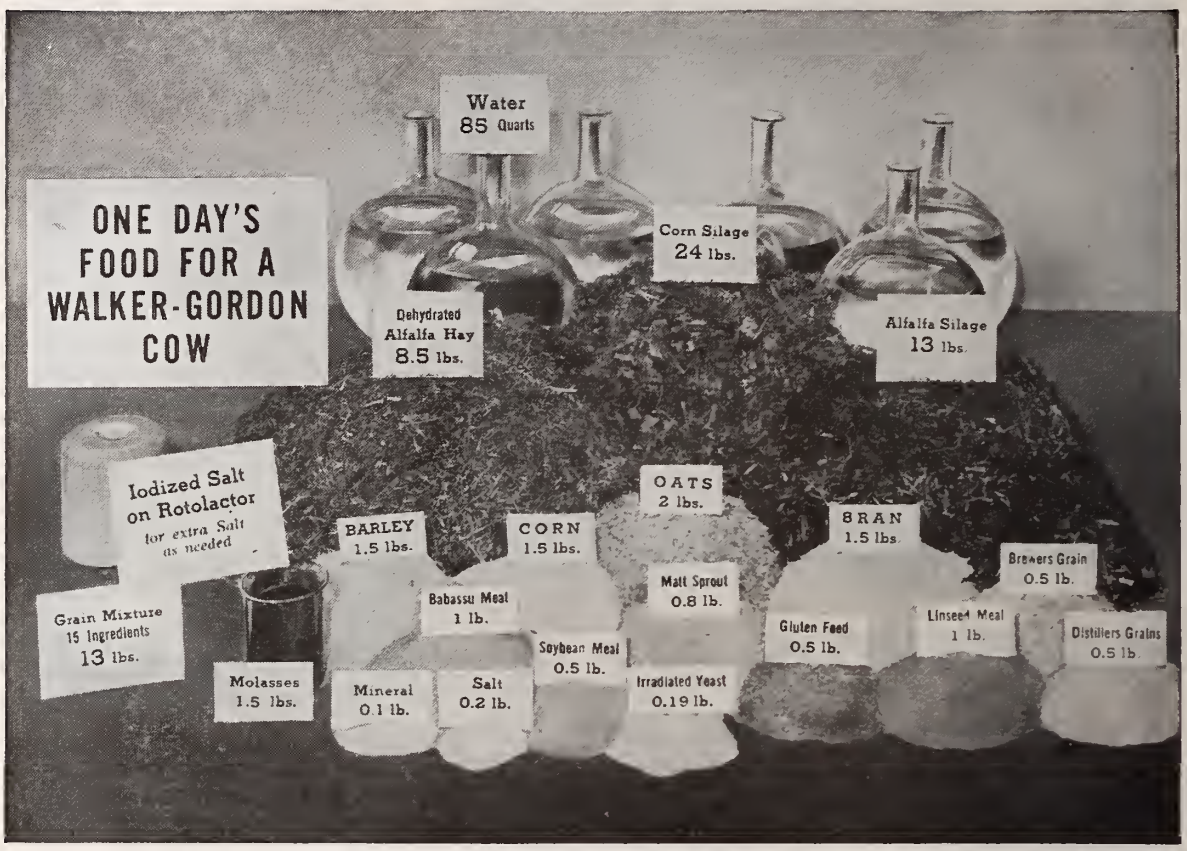
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Esch. coli	*B. pyocyaneus*
B. proteus	*B. lactis aerogenes*
Friedlander's bacillus	*H. influenzae*

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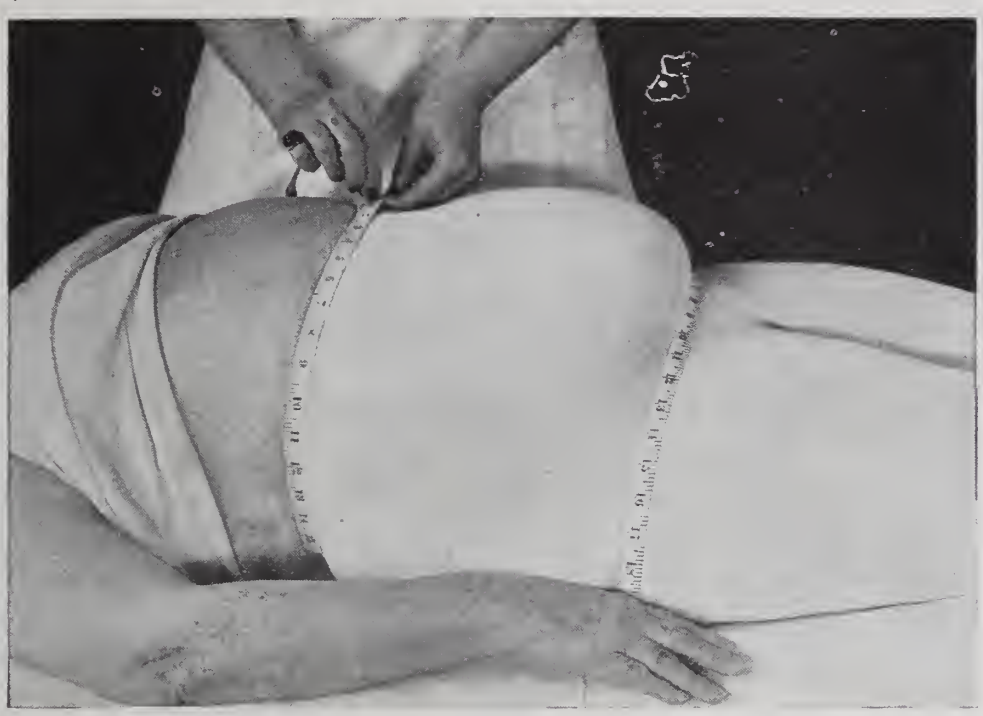
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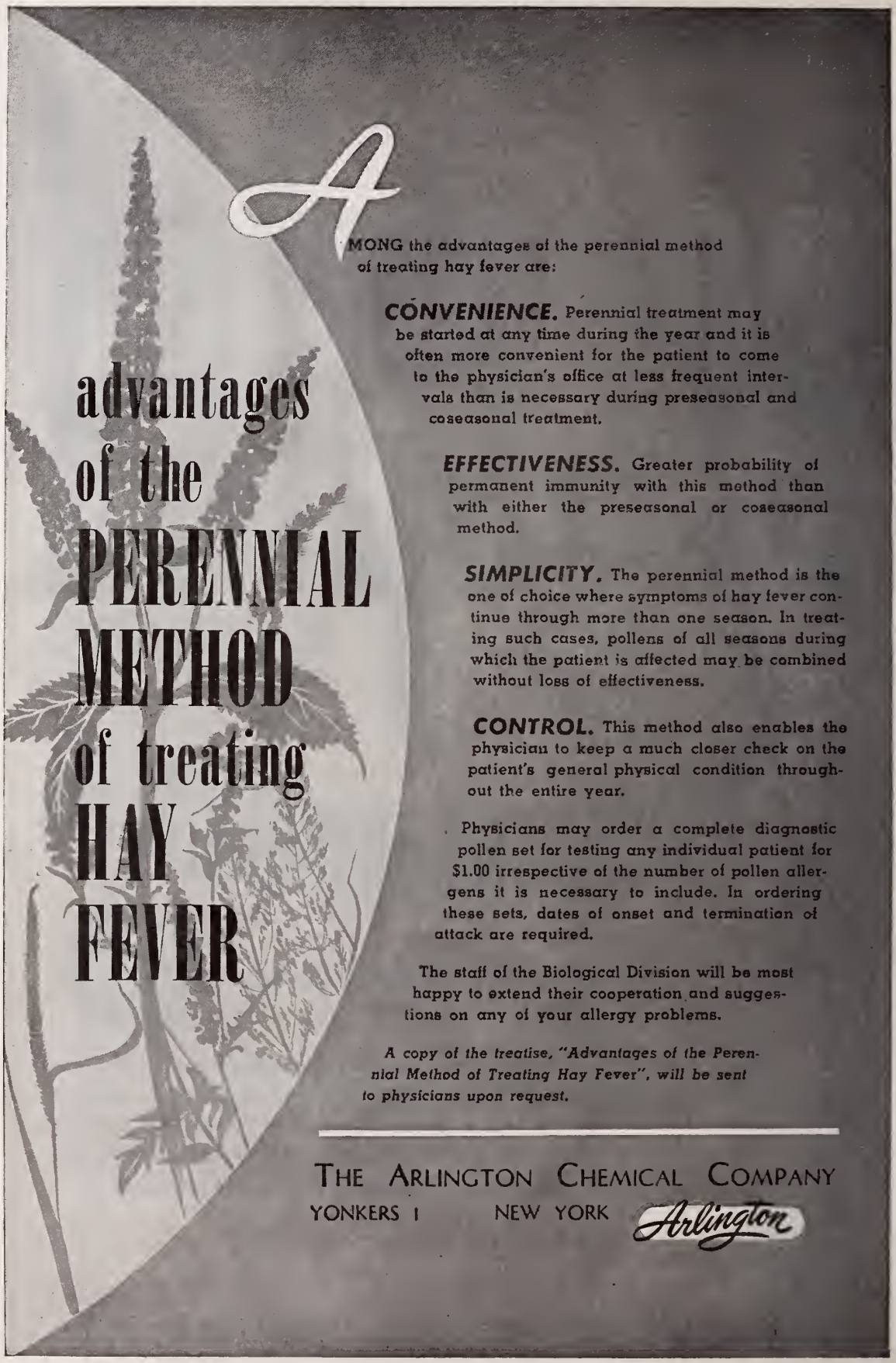
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Dawn of new hope in petit mal . . .

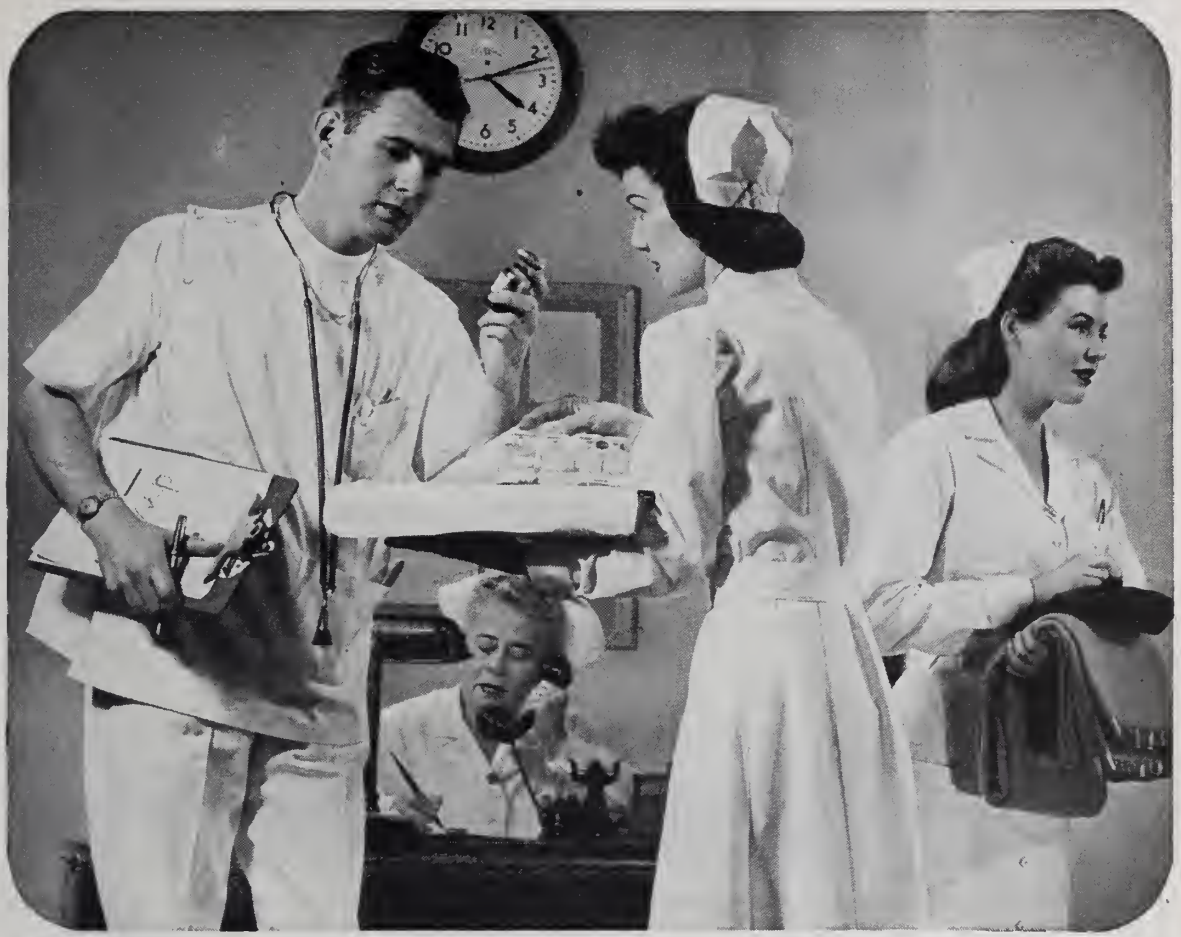
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1. Lennox, W. G. (1945), Petit Mal Epilepsies: Their Treatment with Tridione, J. Amer. Med. Assn., 129:1069, December 15.
2. DeJong, R. N. (1946), Effect of Tridione in the Control of Psychomotor Attacks, J. Amer. Med. Assn., 130:565, March 2.



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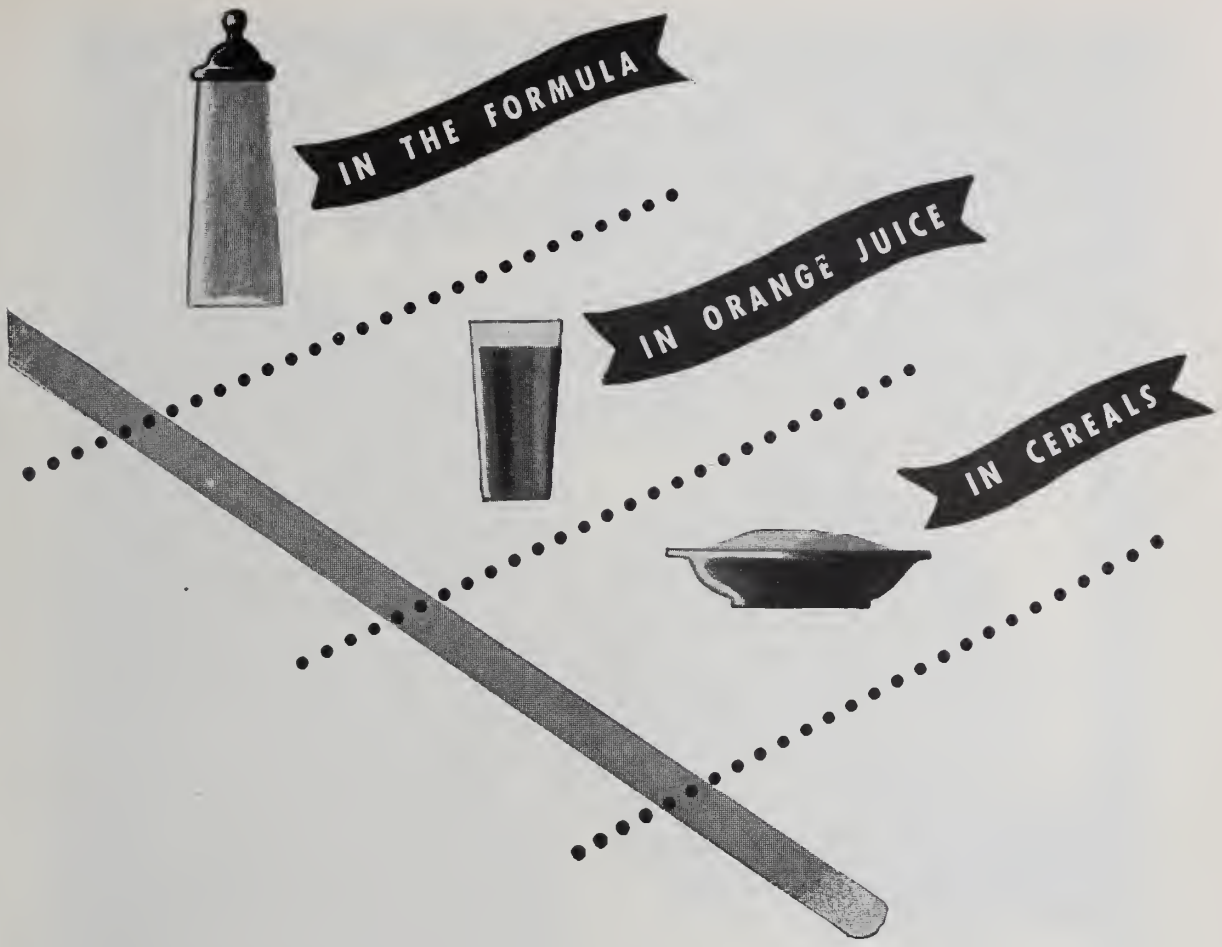
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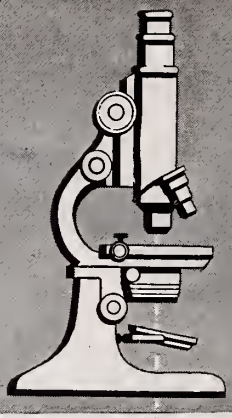


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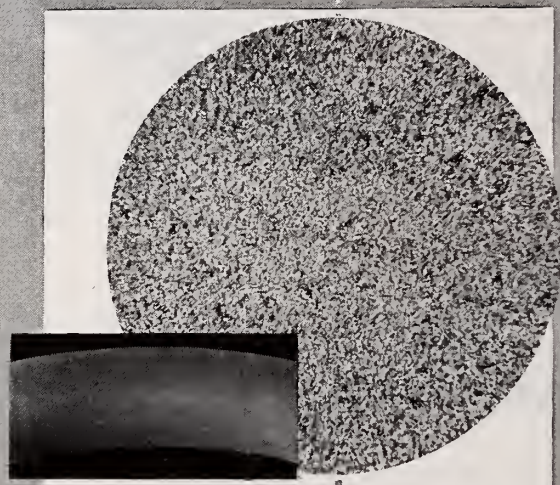
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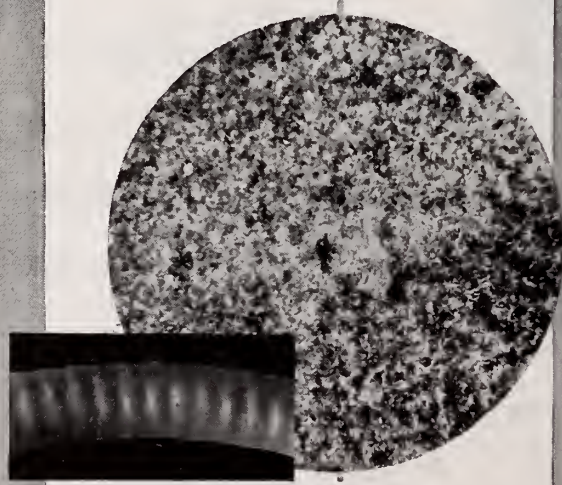
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1. Watson, B. P.: J. Clin. Endocrinology 4:571 (Dec.) 1944.

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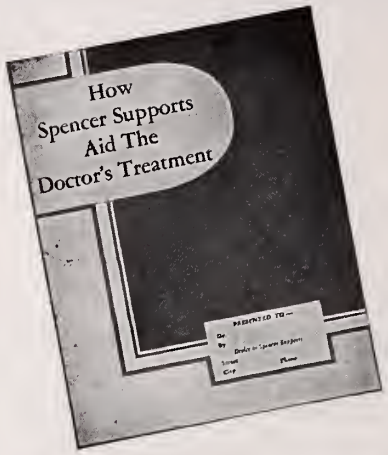
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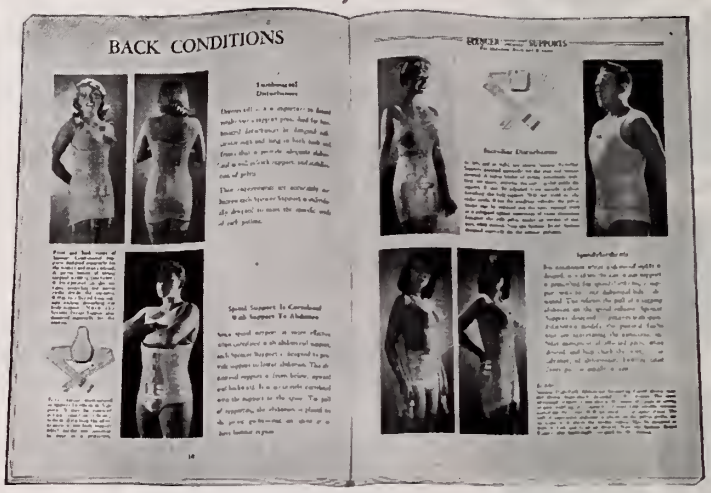
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1. Am. J. Dis. Child. 66:1 (July) 1943.

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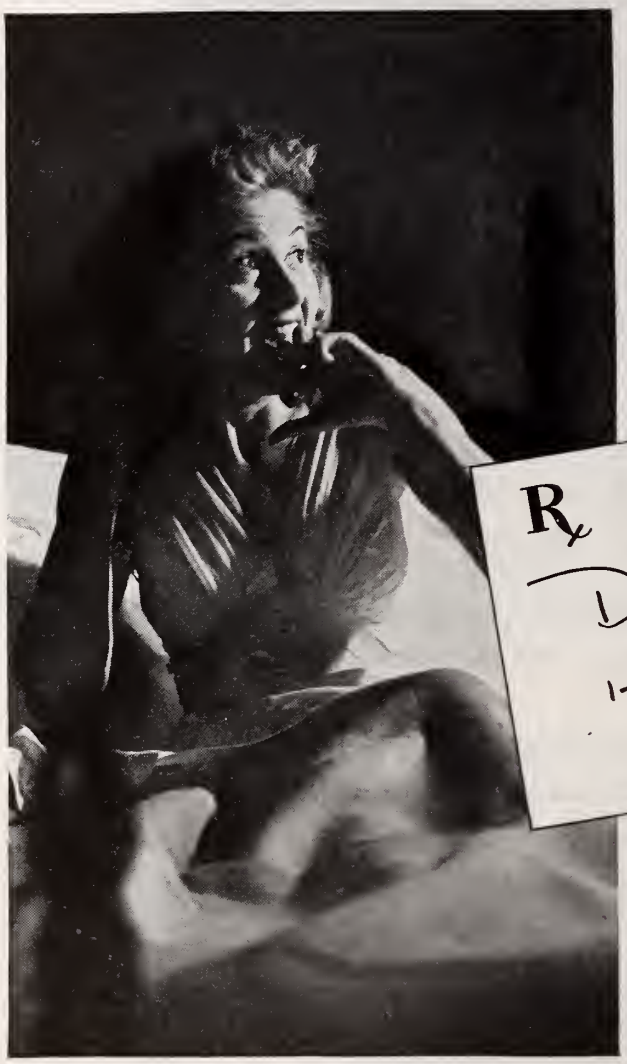
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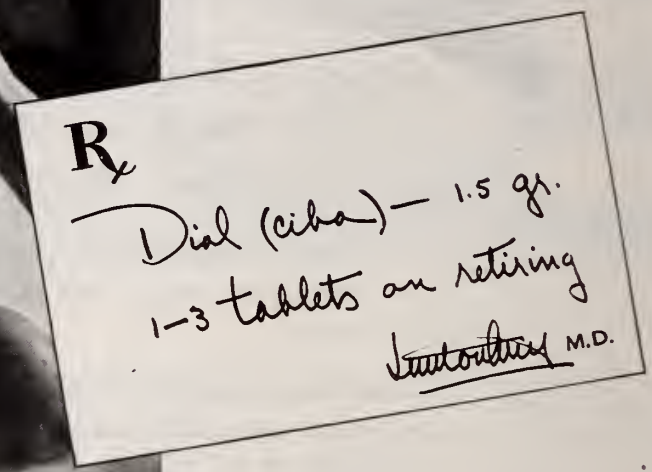
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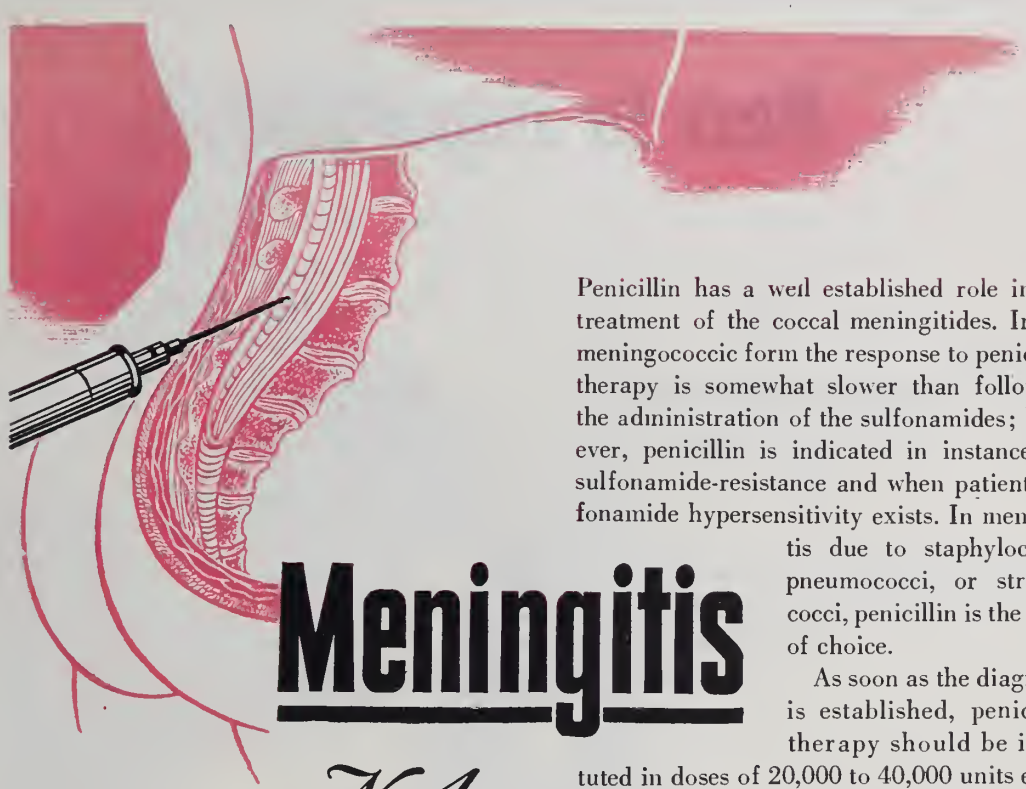
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Meningitis

No. 4

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When concurrent sulfonamides are indicated, they should be administered in a dosage sufficient to establish a blood level of 15 mg. per cent.

Surgical, supportive, and other measures should be employed when indicated.

SPINK, W. W., *and* HALL, W. H.: *Penicillin Therapy at the University of Minnesota Hospitals: 1942-1944, Ann. Int. Med. 22:510 (April) 1945.*

WHITE, W. L.; MURPHY, F. D.; LOCKWOOD, J. S., *and* FLIPPIN, H. F.: *Penicillin in the Treatment of Pneumococcal, Meningococcal, Streptococcal, and Staphylococcal Meningitis, Am. J. Med. Sc. 210:1 (July) 1945.*

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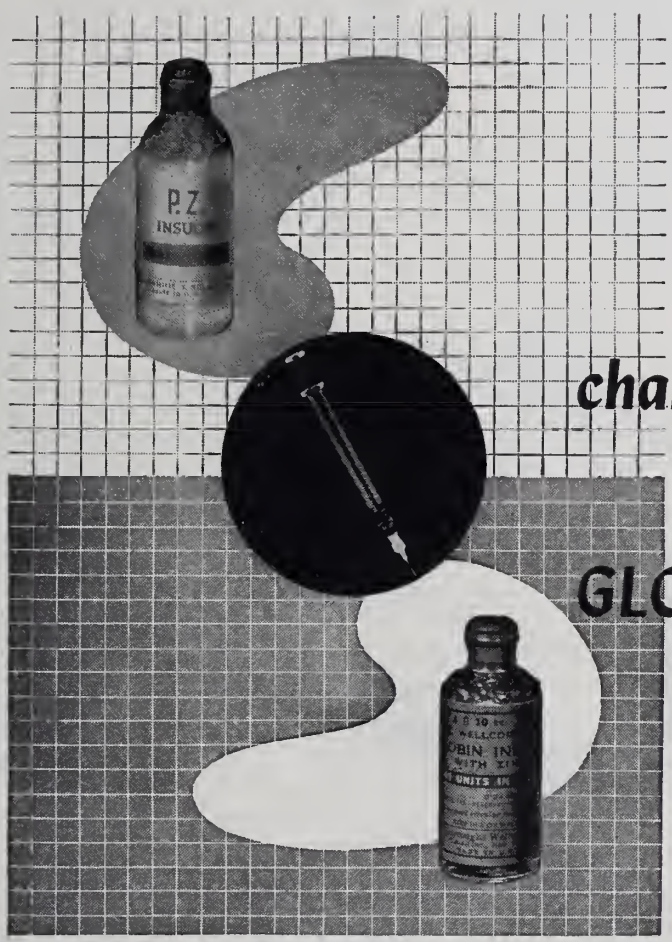
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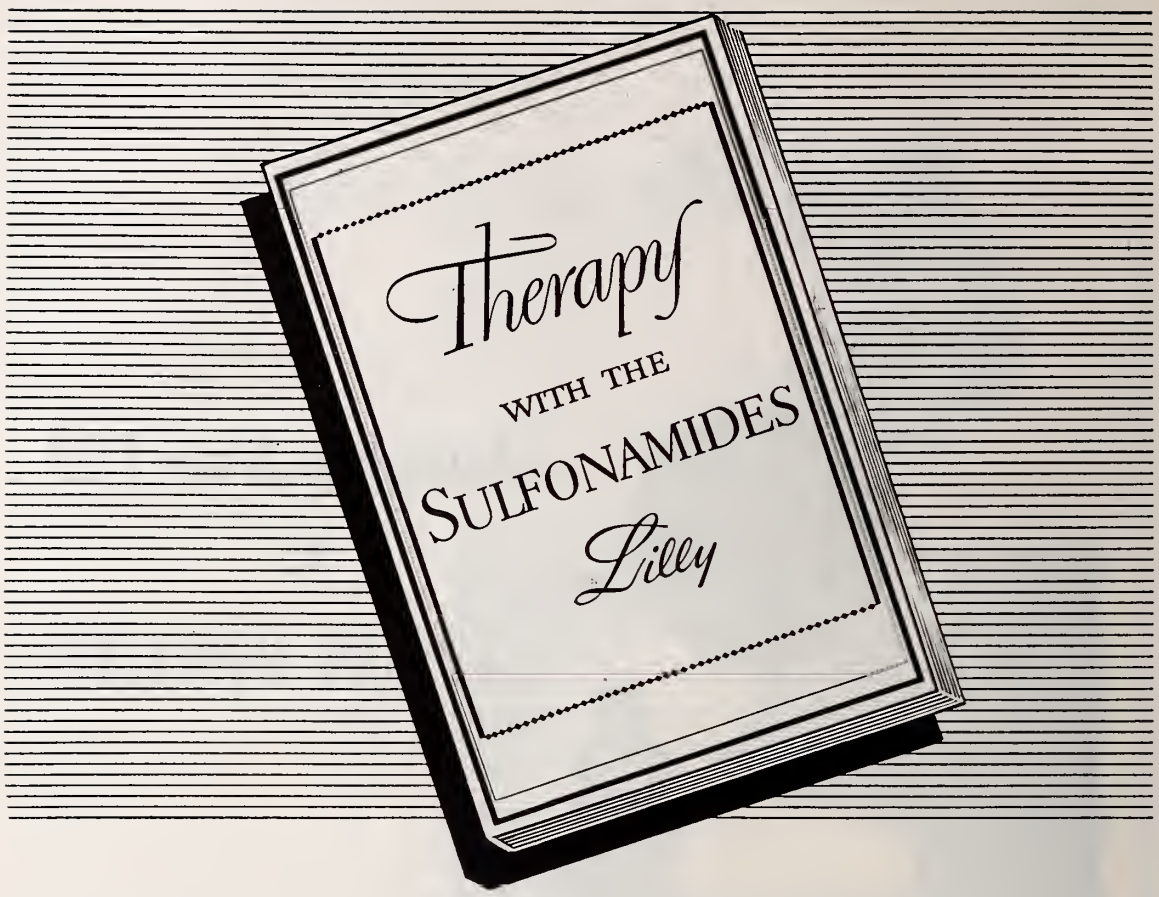
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OF
THE MEDICAL SOCIETY OF NEW JERSEY

Published Monthly Since September, 1904

Whole Number of Issues, 506

Under the
Direction of the
Committee on Publication

Henry C. Barkhorn, M.D., Chairman

Henry A. Davidson, M.D., Editor

Place of Publication, Printing and Mailing—12 South Day Street, Orange, N. J.
Editorial and Executive Offices of the Society—315 West State Street, Trenton 8, N. J.; Tel 5776
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Each member of the State Society is entitled to receive a copy of The Journal every month.

Vol. 43, No. 10 October, 1946 Subscriptions, $3.00 per Year
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WELLS PHILLIPS EAGLETON, M.D., 1865-1946

The dean of the medical profession in this state has died. Dr. Wells P. Eagleton, Senior Fellow of The Medical Society of New Jersey, surely the most vigorous and colorful member in its history, has finally yielded to the old enemy whom he had fought so long and so successfully on behalf of others. Now silent is a voice that for more than half a century had echoed through the halls of our Society, a voice that had at times been admonishing, coaxing, directing or warning—but never a voice that whined or compromised. His passing robs the Society of a truly unique personality. There has never been any one else quite like Wells P. Eagleton.

Dr. Eagleton was born in September, 1865, and died on the eve of his eighty-first birthday. It was a long, rich and valuable life, a span of years that stretched from Abraham Lincoln to the atomic bomb, and displayed some of the characteristics of both. A native of Brooklyn, he came to Newark in 1888 to serve an internship at the City Hospital after his graduation from the College of Physicians and Surgeons of Columbia University. The following year he became a resident at the Newark Eye and Ear Infirmary, and his identification with that institution lasted to the day of his death. In 1890 he entered private practice, and soon thereafter established his office on Lombardy Street. For almost fifty years that office on Lombardy Street was a power house from which radiated some of the mightiest ideas in medical administration, scientific progress and civic activities.

The phrase "many-sided man" has been used so often that it has become a shop-worn stereotype for the obituary writer.

Yet there has never been a man whom it fitted more aptly. His contributions to otology, ophthalmology and cranial surgery won him an international reputation. Of all New Jersey doctors, Wells P. Eagleton was probably the only one whose name would be recognized among physicians anywhere in the world. His labors in civic and welfare causes made him one of the most distinguished citizens of his community. Few are the doctors whose passing would be marked by editorials in the state's largest newspapers. His work in organized medicine was far-reaching and significant. The gift of an entire building to the Academy of Medicine was but a symbol of his stake in organized medical activities.

Wells P. Eagleton accumulated almost every honor that a respectful profession and a grateful public could bestow. As far back as 1908, he was President of the Essex County Medical Society. In 1920 he was elected President of the American Otologic Society. The following year he was selected as chairman of the Newark Council of Social Agencies. In 1923 he became President of The Medical Society of New Jersey. In 1929 he was elected President of the New York Otologic Society. In 1931 he was President of the Academy of Medicine of Northern New Jersey. Three years later he was chosen to head the American Academy of Ophthalmology. With the establishment of Edward J. Ill Award by the Academy of Medicine, he was the inevitable choice as first recipient of that honor. The list could be extended indefinitely.

What stimulated so many and such varied groups to shower honors upon him? Certainly he did not win acclaim by being obsequious. He never followed a policy of saying agreeable things to everybody just to win universal approval. On the contrary, he entertained sharp, clear-cut views on almost every subject under the sun and made no secret of any of his views. Once he decided on a course of action he moved in that direction without making a detour or losing his pace. You might not agree with his point of view. Indeed, any one who espouses a controversial cause with full vigor and no compromise is certain to stimulate opposition. But whether you agreed with his opinions or aims or whether you didn't, you had to admit that here was a man who knew what he wanted and who would go straight to the point.

Dr. Eagleton probably attended more medical meetings than any doctor in the history of New Jersey. When he came to a meeting, he would not sit in the back row and join in the chorus when the chairman said, "All in favor say 'aye'." He was essentially a solo performer and you never had any doubt as to where he stood on an issue. You never had any doubt because he got up on his feet and told you. And when he failed to appear at a meeting, his presence was felt anyway. Decisions were rarely taken without weight being given to what he would have thought and said about it. Now they say that he is dead. But in a larger sense that cannot possibly be. For many years to come there will be a ghostly voice heard in the counsel chambers of The Medical Society whenever anyone wants to take a backward step or compromise on a matter of principle. The whisper may be inaudible to the bystander, but those familiar with the Society will recognize it plainly enough. It will be the invisible but potent presence of the Senior Fellow, the magnetic and impelling voice of Wells P. Eagleton.

GIVE THE V. A. A CHANCE

In a somewhat churlish interview last month, an anonymous physician made page one of a New Jersey Sunday newspaper by scolding the Veterans Administration. It seems that the poor doctor had done a large amount of work for the V. A. and that that agency was several months behind in reimbursing him. Let it be remembered that if it were not for his scapegoat, he would never had had this handsome accounts receivable; and that the finance department of the Veterans Administration is going to pay pension and subsistence claims as well as meet doctors' bills. There are only certain amounts of time and personnel available for authorizing and making payments. Some priority order must be established. And it is altogether proper that payment to veterans of pensions or subsistence take precedence over payment to doctors, most of whose income comes from outside sources. It is ungracious, indeed shameful, for a physician to insist that he be paid first while the disabled veteran waits for his monthly pittance. It bespeaks no largeness of mind or charity of understanding when a doctor demands that he be paid even if it means that a veteran-student, devoid of other means of support, must go without his subsistence check. A doctor in private practice is not supposed to draw a large part of his income from the Veterans Administration. The entire project, it must be remembered, is set up to help veterans, not doctors. If V. A. work represents only a small fraction of the practitioner's income, this loud insistence on immediate payment is a sorry commentary on the profession. The Veterans Administration must check and double-check every bill. Anything short of that would be an open invitation to racketeering. And this process of carefully scanning every item, of cautiously pairing each bill with the authorization, of verifying the government's obligation, all this is the kind of good bookkeeping practice necessary to protect public funds. Calling it red-tape does not alter the fact that the procedure is essential to the protection of the public treasury. Doctors are large taxpayers and as such should be gratified at the meticulous care taken by government auditors. The money legitimately owed by the V. A. is the safest accounts receivable a physician ever had. The impatient doctor, hungry for his cash, should be reminded that he would be well off indeed if all his debtors were as dependable as Uncle Sam.

THE PHYSICIAN AND THE FARMER

Disquieting stories about the medical profession are being heard in our rural areas these days. It is rumored that some physicians in agricultural districts are cool to the Farm Security Plan, that they do not see why they should treat patients at only $2.50 a house call, that they look at the apparently prosperous farms of this agency's clients and grumble at the small fees paid under the plan. It is hoped that these rumors are groundless and that no physician who has elected to serve the New Jersey rural population will so badly let the farmer down: not to speak of letting down his own profession. The facts are these: no family becomes a beneficiary of the Farm Security Administration unless it is in real financial difficulties. The farmer who leans on FSA aid is a man who needs money for essential repairs or for the restocking of his farm, but who has no assets on which to base a private loan. After determining the worthiness of the application, the FSA lends money which makes it possible for the client to rehabilitate his farm. Except

for modest withdrawals based on minimum needs, the client's farm income is completely earmarked for repayment of the loan. For a small subscription rate, the family is permitted to purchase health insurance on a purely voluntary basis. These subscriptions cannot support a greater reimbursement schedule than the $1.50 per office visit or $2.50 per house call now allowed. The medical plan is an honest effort on the part of these low-income farmers to pay for their own care. Let it be noted that the government does not pay the doctor; the farmers pay him —and they do this through voluntary prepaid insurance. The beneficiaries are self-respecting farmers in the low-income group who, without this project, would become medically indigent. They don't want charity and they don't want government-salaried doctors. If the medical profession refuses to cooperate, one of these other alternatives is inevitable.

Physicians are always emphasizing the importance of individualism, freedom from government control, and their willingness to meet the honest patient half way. Here is the New Jersey farmer, surely the most ruggedly individualistic worker in the state, who wants to choose his own doctor and pay the modest fee that he can afford. Will the rural practitioner exclude him from care or press on him the unnecessary stigma of a "charity patient"?

Rehabilitation of the farm family raises the entire economic level of the rural community. The local practitioner will share in any such economic improvement. Nonparticipation, on the contrary, helps depress economic conditions locally by impairing the effectiveness of the FSA program. These are practical reasons for cooperating with the project. Even more important, however, are the other reasons: a demonstration to the public that the medical profession will cooperate in a voluntary plan, and a willing answer to a call for help from one of the worthiest citizen groups of all, the American farmer.

A BARGAIN IN SERVICE

Would you like to purchase a bargain package of unusual value this fall?

It is a bargain in service to you and your neighbors. It will help you both and it will make your community and your nation a better place in which to live.

Great interest is being manifested in the Community Chest and USO campaigns for funds this fall. These funds support the private health, welfare and recreation services seeking to alleviate social problems in your community. They also help to continue the USO "home away from home" for our men still in far away places, in hospitals and in training.

Besides the local services supported through Community Chest campaigns, this year most of the Community Chests in the United States are planning to raise their share of the USO national campaign goal. In some towns, where the appeal is not to be federated, USO will conduct its own campaign through state and local committees.

In addition, many cities are raising funds for some of the war relief organizations whose tasks must be continued temporarily.

This is a bargain package. In one campaign, Community Chests are enabling citizens to make a single contribution to cover most of the community services that the city affords. It is a purchase that every American should make.

Give generously and now to the USO and your Community Chest.

ORIGINAL ARTICLES

PROGRESS IN REORGANIZATION OF MEDICAL SERVICES IN THE VETERANS ADMINISTRATION*

Major General Paul R. Hawley, Washington, D. C.
Chief Medical Director, Veterans Administration

I am a little bit overwhelmed with the toastmaster's introduction and not a little touched. The toastmaster a few minutes ago questioned the ability of other guests to stand on their feet, and I, who attended the cocktail party this afternoon, when I walked in the door this evening, thought of the story of the pink elephant who walked into a barroom at five o'clock in the afternoon. The bartender glanced around and said, "You're too early; he hasn't come in yet."

I apologize at the outset for my voice. I am not such a good doctor as the toastmaster told you, because I have had this for two months. It is getting better, but if I don't get well soon, I am going to see an osteopath and then I am sure I will be all right.

But with this voice I find myself, or you, or both of us, in one of the other positions of the British Land Army girl, up at the crack of dawn, working in the fields until the sun went down, with little recreation. One night she went on a very large party—in fact, it was an exceedingly large party, and she got up next morning before daylight with such a terrific hangover that she could scarcely see. Her first chore was to milk a cow.

She went out and tried her best but was making very heavy weather of it and getting very little milk, when finally the cow turned around and said, "Never mind, dearie, I know just how you feel. Now you hold on and I'll jump up and down."

So, if you hold on, even with this voice I can at least jump up and down.

Now, one trouble about toastmasters is that they make everybody's speech for them. Three, or four, or five things which I wanted to say first, the toastmaster said for me. First I wanted to say what a great pleasure it is for me to be here, as well as a privilege. It is a pleasure to see the doctors here, back from the services, who really did the work. I concur thoroughly in the statement of the toastmaster that it was the doctors at the front who did the work.

If I had now in the Veterans' Administration just one-fourth the doctors I had in the European Theatre, I would go fishing every day, and I wouldn't have to keep my nose to the grindstone trying to get this service in shape.

Another thing I wanted to do was to pay tribute to Mrs. Alexander, and I take a considerable amount of credit for having raised her in the European Theatre, and for sending her to the Mediterranean Theatre, where she honored all of us as well as herself by becoming superintendent of Nursing Service in that Theatre. But let no one forget that we brought her up in the European Theatre before she went down there.

Now I have taken this occasion to come before you to make some sort of accounting for what I consider a stewardship for the medical profession of this country over the past six or seven months that I have been with the Veterans' Administration.

I consider myself responsible to three people, or rather to three groups of people. Obviously, my primary and my first responsibility is to General Bradley, who is the Administrator of Veterans' Affairs. Then I consider myself very responsible to the veterans of this country, that I shall give them the kind of medical service that they have earned—no more, no less—because they have earned the best of medical service.

But last, and not at all least, because it is all tied together in one project, I consider myself very responsible to the medical profession of this country—first, that I practice the kind of

* Delivered at the Annual Meeting of The Medical Society of New Jersey in Atlantic City May 22, 1946. This talk was not prepared in advance but given extemporaneously and taken down by the stenotypist. The transcript has been approved by General Hawley.

medicine in the Veterans' Administration that the medical profession of this country wants to see practiced; and, second, that in that practice I preserve the ideals of medicine in every respect, not only professional, but also ethical and, shall we say, the social ideals of the practice of medicine.

THE V. A. BEFORE 1944

Before we can at all measure the progress that we have made in the Veterans' Administration, we shall, I think, make a very brief survey—a brief summary of the situation that the Veterans' Administration Medical Service was in a few months ago when General Bradley took office.

There had at that time just been made very serious attacks on the medical service, which were widely publicized. The gist of these attacks was that there were very poor personnel in the medical service and even this poor personnel was very scarce in quantity, in numbers; and that patients were badly treated; that they were even abused in many of the Veterans' Administration Hospitals.

Well, it is a very curious feature of the press in this country that nothing that is good is news, that it must be spectacular and bad before it is worthy of publication, and this was true in many of these published attacks. Now, some of these charges *were* true—unquestionably they were true — and some of these charges, I am very much ashamed to have to tell you tonight, could still be leveled at some of our hospitals; but there are many things that were either not quite true, or had extenuating circumstances beyond the control of the Medical Service.

General Bradley and I fell heir to a house, an old house, a house that we had to live in. Any of you who have tried to remodel an old house know that in the first place, you are let in for much more expense than if you had torn it down and started in and built the kind of house you wanted to start with. Well, that was impossible. We had to live in this house.

Well, obviously, if you had work to do on it, to tear out, you wouldn't move into it before the contractors had completed the remodeling. You would stay away and give them a free hand. That we couldn't do, so we were in the position of moving into an old house. However well it was built in the first place, it was certainly full of dry rot, and was sagging, and the foundations were bad, but we couldn't move out while it was being shored up. We had to live in this house and remodel it while we were living in it, with the load increasing tenfold as the Army and Navy were demobilized.

CAUSES OF THE DETERIORATION

What were the causes of the deterioration of this house? I refer particularly to the Medical Service. I scarcely know in what order to put these causes because I imagine they affected different individuals in different ways; but first, perhaps, at least the thing which is generally thought, but which I do not believe to be true about doctors in general—first was the poor pay. There were large numbers of doctors who worked years in the Veterans' Administration on salaries of less than $5000 a year. The pay, certainly we can say, was not attractive.

The next thing was the domination, the complete control, the strangulation of the Medical Service by Civil Service. Now, I am not here to attack Civil Service as a principle in government operation, but I can tell you very frankly that it is just no good for the operation of a medical service. Civil Service rates a position and you must find somebody who can almost fit into that position. Then you give him that grade and the pay of that position. Well, you can't grade doctors that way. You have got to grade doctors by what they know, what they can do, what their training is, what their experience is, and then find a position to fit that training and experience.

Thus, in a 700-bed hosptial, for example, the Chief of the Surgical Service could rate what Civil Service called a P & S 6, and be paid somewhere between $6000 and $7000 a year. But in a 400-bed hospital you could pay the Chief of the Surgical Service perhaps $5500 a year; and in a 200-bed hospital perhaps $4500 a year.

Now, in so far as the patient is concerned, whether he is operated upon in a 200-bed hos-

pital or a thousand-bed hospital, he wants just as able a surgeon and, in many of these isolated, smaller hospitals where consultation with able men in the civil community is not available, it is much more important to have the more experienced surgeon, one who is self-reliant, who doesn't require the help, than it is in some of the large hospitals around metropolitan areas. But this was impossible to do under Civil Service. Civil Service is a very rigid, inflexible system. It may work very well for bookkeepers, but it doesn't work for doctors.

Another cause for the deterioration of the Medical Service was the pressure groups. I am not going to get involved in any political arguments. There are too many newspaper reporters present for me to become explicit about this; but I shall say that the files of the Veterans' Administration are full of correspondence asking that this doctor be promoted, protesting against that one being transferred, from all types of pressure groups. You can't run a medical service that way.

Another factor was that the Medical Service was submerged completely under an unsympathetic lay administration. The Medical Director of the Veterans' Administration had no access whatsoever to the Administrator of Veterans' Affairs, despite the fact that the Medical Service was the biggest operation within the Veterans' Administration. The Medical Director was buried down under two or three layers of lay administrators who were making medical decisions.

Under such a system, obviously there was no medical leadership. The doctors couldn't look to anybody to fight their battles—somebody who understood them and who could go to the Administrator and, if necessary, lay it on his desk and say, "This is medical business, and you lay people don't know what you are talking about."

Now, that, in general, I think, rather sums up the causes for the deterioration of the Medical Service at the Veterans' Administration. When we came in, we found doctors discouraged, we found them resentful, bitterly resentful of the attacks that had been made; in fact, there had developed rather a defense reaction in many of them, a distorted perspective, to the point that they were saying it was the greatest medical service that had ever been organized, and the people attacking it were foolish. Of course, the truth lies somewhere in between.

Now, I have made a lot of generalizations here, and I want to stop at this point and quote Voltaire, who said that no generalization is true, including this one; and so no remarks that I have made here apply to every doctor, but I have tried to give you a cross-section of the feeling which we encountered when we came into the Veterans' Administration.

TOWARDS A NEW PROGRAM

Out of this, among some of the older men in the Veterans' Administration has grown a suspicion of the new program that we are trying to establish. That again is not general. Many of our strongest, most loyal supporters are men who have spent twenty or twenty-five years in the Veterans' Administration; and they have come to me and said, "We prayed for this day to come." But I would be less than frank if I didn't acknowledge that I think that there are some men now in the Veterans' Administration who are suspicious of this program. They are suspicious of me. They are suspicious of what we are trying to do.

After you have lived a long time in the government service, and I realize I am laying myself open on this, having lived thirty years in government service, but in a different kind of government service, people are inclined to develop a feeling of vested rights in their positions and anything, any change, which may in any way affect the stability of that position is viewed with the deepest suspicion.

Another curious thing about this is that many of the people who attack the Medical Service, or who attacked it a few months and are now protesting just as loudly when we try to remove a doctor who is no good. American people are curious people.

Of course, our answer to this whole thing is, "For whom are we running this Medical Service? Are we running it for the doctors or for the patients?"

As I told you, under Civil Service it is im-

possible to do anything. We recruited scarcely no one between October and the 31st of December. We were operating under Civil Service. Good doctors would have nothing to do with it; and so we supported a bill which we didn't write, but which was written by the Congress and which became public law 293.

Before General Bradley and I came to the Veterans' Administration there had been a bill to create a medical corps within the Veterans' Administration. This bill had the support of the large number of doctors in the Administration and, with certain modifications which we submitted to the Congress, we supported that bill.

There were many attacks on that bill, principally, curiously enough, because it was said that it created a military corps, although it was modeled after the Public Health Service bill. But the war being over, everybody was suspicious of the Army or anything connected with it, and so Congress came out with a substitute bill written in the committee in which we were able to keep, we felt, the majority of the good points of the other bill; and, as I told that committee time after time, I am not interested in what titles are given to doctors. We don't want rank; we don't want uniforms. All I am interested in is an opportunity for doctors and something which will attract good doctors.

THE NEED FOR MEDICAL PERSONNEL

At the time that bill was signed by the President, the estimated need in doctors for full-time services of the Veterans' Administration was about 3600 physicians. We had at that time about 2400, of whom 1780, almost two-thirds—were lent to the Veterans' Administration by the Army and Navy, and would pass out of our service as they were separated from those services.

That was a rather terrifying situation. We already were short one-third the doctors we would need, and we stood to lose two-thirds of those that we already had. It would have been impossible under Civil Service ever to have recruited replacements for those doctors; however, with Public Law 293, which does offer more to doctors in the way of professional advancement and in the way of pay, than any Federal medical service has ever offered doctors, since the first of January until the 17th of May we have built up, despite severe losses in military personnel, our Medical Service of full-time physicians, from 2300 to 3300, and we now have instead of 1800 men on loan from the Army and Navy, only 800, and so we are over the hump. We have more men now full time, not connected with the armed services than we had, including the 1800 lent by the services on the first day of January. But that is not all the doctors we have, by any means. Those are full-time doctors who have entered the Veterans' Administration service as a lifetime career.

QUALITY OF V. A. MEDICAL PERSONNEL

In addition to those we have 380 attending physicians, each of whom spends at the very least a half-day in charge of a service in the Veterans' Administration Hospital, each of whom is a diplomate of his specialty board. We have three hundred and seven consultants, each of whom is of professorial rank in a school of medicine, and we have in training 436 residents in approved residencies in Veterans' Administration Hospitals. By the end of this year we shall have more than one thousand residents in training.

We have ten applications for resident training for each position that we can now establish, and we shall have four or five applications for each position that we will have been able to establish.

Never before in the history of the Veterans' Administration has there been such a high quality of doctors and each week the quality of doctors applying for appointment in the Veterans' Administration improves. There are more men with excellent training applying; in fact, at the moment, since our building program will not be completed for two years, we are right now having a little difficulty placing as Service Chiefs these men of eminent qualifications. We are having to ask them to go in as Assistant Chiefs of Service until our new hospitals come in, or to take Sections at the same grade and pay.

And here is another place where we are so

fortunate in being out from under Civil Service, because we can pay the Assistant Chief of Service as much money as we pay the Chief of Service, which we could never do under Civil Service; and with this large resident training program which is getting more and more enthusiastic support from the schools of the country, I feel that within a very few years we shall be raising up and training our own replacements, and will have to do very little, if any, recruitment outside.

I am not going into the details of our association with schools of medicine except to say that we are very grateful to find the schools themselves now getting tremendously enthusiastic about this program. The schools have seen the advantages in graduate training, the advantages of medical education.

NEW JERSEY'S ROLE

I am particularly pleased that our whole plan for outpatient treatment was started here in New Jersey — specifically in Monmouth County. I am glad to see Dr. Herrman here tonight. These Monmouth County physicians are the people who came to us with a really workable plan: every other plan in the United States has grown out of that public spirited, well thought out and unselfish plan which originated in Monmouth County, New Jersey. My hat is off to those people.

CAPACITY OF V. A. FACILITIES

Another thing we have been able to accomplish is an increased efficiency in the plant we now operate. In one hospital, after we had got it in operation with the university, within one month, output of the surgical service was up 650 per cent, and of the medical service 250 per cent over any previous experience in that Veterans' Hospital.

The capacity of the Medical Service of the Veterans' Hospital Administration to take care of the veterans is not to be measured in the number of beds we operate and the number of hospitals we have built, but in the number of patients that we treat. The output of all of our hospitals now in association with schools of medicine, with enough staff and good staff, and residents to work these cases up fast, is up so high—75 or 80 per cent over anything that was ever done in the past—that I am confident that within a year or eighteen months, the total average output (including even neuropsychiatric and tuberculous cases as well as the general medical and surgical cases) of patients per year in the same number of beds wil be up 50 per cent over anything that it has ever been before.

What does this mean? At the end of this building program which is now in progress, we shall have 150,000 beds in the Veterans' Administration Hospitals. With increased efficiency we shall have added 75,000 beds to that 150,000 beds, without ever laying one brick on top of another. You taxpayers ought to be interested in that. If we had to build those 75,000 beds in order to get the same output as under the old terms of management, it would cost us at present not a penny less than one billion dollars, and it would cost us 150 million dollars a year to operate those additional 75,000 beds, which we shall never have to build and never have to operate, if we can, as we know we can, raise the efficiency of the plant.

RELATIONS WITH THE MEDICAL PROFESSION

I made certain definite promises to the physicians of this country through the American Medical Association a few months ago. We haven't any intention of changing anything that we said. The policy of the Medical Service of the Veterans' Administration is unchanged and there is no indication of change. We are going to work with, and not against, the medical profession of this country; and we know that the medical profession of this country is at the moment working closer with us than they did at the start.

There is a definite threat of regimentation of medicine in this country. All of us who love medicine for itself rather than what it brings to us, and that includes most doctors in this country, know that that will be the worst thing that can ever happen to the practice of medicine. We have all of us to fight regimentation of medicine—you have got to fight it—and in so far as it lies within my power, bound by law, bound by government directives—in so far as it lies within my power, I, too, shall fight it.

THE USE OF OXYGEN BY THE GENERAL PRACTITIONER

RICHARD E. BRENNEMAN, M.D., Merchantville, N. J.

Many diseases and anoxic states are helped by oxygen therapy. It is especially valuable in acute anoxemia which may be of an anemic, anoxic, stagnant or histotoxic nature. Anoxic anoxemia results when the arterial blood cannot be properly oxygenated in the lung tissues. This may be because of insufficient oxygen in the inspired air or because of disease of the respiratory system. Anemic anoxemia occurs when the blood is unable to carry a sufficient amount of oxygen because of pathologic conditions or deficiency of the hemoglobin. This occurs in anemia. Stagnant anoxemia exists when the blood flow becomes retarded so that the hemoglobin loses its oxygen too soon. This may be found in cardiac failure. Histotoxic anoxemia is another type of anoxia in which the tissue cells are poisoned or impaired and are unable to take up and use the oxygen brought to them. Oxygen is less valuable in chronic anoxemia because the body has attempted to adjust to the slower progress of lowered oxygen in the blood. It occurs most often in cardiac diseases which are congenital or slow in making their appearance.

CLINICAL INDICATIONS

Oxygen is helpful in all cardiac conditions, especially the acute ones or those that show signs of an acute anoxemia. This accounts for the relief of pain resulting from ischemia in acute coronary occlusion. The angina pectoris associated with occlusion is alleviated by relieving the anoxic condition of the heart muscle. Oxygen is of benefit in congestive heart failure, coronary arteriosclerosis and cardiac insufficiency because it relieves the state of anoxic anoxemia or stagnant anoxemia which may exist. It is not a panacea in these cases but offers relief to the sufferer and acts as an aid toward a cure.

The symptoms of lowered vital capacity of the lungs are benefited by inhalations of oxygen. The lowered vital capacity may be present because of atelectasis, pulmonary edema, pulmonary fibrosis, emphysema, pneumonia or other conditions in which the amount of oxygen reaching the blood is reduced. The benefit is derived by alleviating the distress of air hunger and increased cardiac output which may have occurred because of oxygen want, increased metabolic rate, cellular malnutrition and intoxication. The increase of oxygen in the bloom stream produced by inhalations of greater concentrations of oxygen through the functioning part of the lung is the important factor which gives the relief to the patient. There is easier breathing and the pulse becomes slower. The burden upon the heart is lessened and there is a tendency to combat the anoxic anoxemia which exists. If the diseased condition is advanced the resultant stagnant anoxemia from an over-burdened heart, or the anemic anoxemia or the histotoxic anoxia which may result from intoxication may be lessened. Thus, the natural defenses of the body which are depressed by anoxemia are allowed to combat the diseased condition more readily.

Inhalations of 100 per cent oxygen are helpful in combating carbon monoxide poisoning which presents a picture of anemic anoxemia as well as histotoxic anoxia. The affinity of carbon monoxide for the iron of hemoglobin is two hundred times greater than that of oxygen, yet oxygen can replace the carbon monoxide by increasing the oxygen tension of the blood. As pure oxygen is inhaled, more and more oxygen is in physical solution and, therefore, anoxia can be combatted even in the presence of the carbon monoxide in combination with the hemoglobin.

There is a definite oxygen want in the hyperpyrexia and toxemia which occur in diseased conditions. This is the result of the increased metabolic rate and anoxemia. There is less restlessness, mental confusion and excitement if inhalations of oxygen are given. Studies have shown that there may be a normal arterial oxygen saturation but a reduction in oxygen tension because of the alkalosis present during fever. Oxygen therapy increases the oxygen tension. There is an increased amount of oxy-

gen in physical solution in the plasma and this oxygen is readily available to the tissues and is not dependent upon dissociation of hemoglobin.

Oxygen therapy has proved to be of value after operation by avoiding or combating anoxia. Administrations of oxygen are especially helpful after operations on patients who are poor surgical risks. Oxygen tends to ease the burden of the heart, increase nourishment to the tissues and resist any anoxemia or anoxia resulting from circulatory collapse or shock. The important rule that oxygen be given early applies particularly to these cases. It should be administered as soon as the patient returns to bed or continued if it has been necessary to begin its administration in the operating room. One hundred per cent oxygen also quickly washes out the inert nitrogen from the lungs, then most from the blood and finally from the tissues. Thus, a great part of the nitrogen is removed from a distended bowel which relieves the distress that may be present.

Some types of headache of undetermined origin can be relieved by inhalations of 100 per cent oxygen. This treatment is also useful in cases of spinal puncture headache, alcoholic headache and seasickness.

In respiratory arrest or shock it may be necessary to give oxygen under positive pressure. Care must be taken not to over-distend the lungs and cause air emboli. The aim is to get oxygen into the lungs by simulating normal breathing as nearly as possible so that the inert nitrogen and carbon dioxide are removed. The blood stream then is able to obtain sufficient oxygen.

Many other disorders can be helped by administration of oxygen. These are classifiable as one or another of the forms of oxygen lack already discussed.

SIGNS OF OXYGEN WANT

It is important to recognize the common clinical signs of oxygen want. They are: (1) Increased rate and depth of respiration progressing to rapid and shallow breathing. (2) Increased pulse rate. (3) As oxygen lack becomes aggravated, diastolic pressure falls. (4) Hypoxia of the gastro-intestinal system leads to nausea, vomiting, and eventually diarrhea. (5) Affection of the central nervous system produces symptoms, such as headache and disturbances of vision, which progress to delirium, coma and eventually death.

TECHNIC OF ADMINISTRATION

Oxygen is best given by inhalation. The intranasal catheter is an excellent method for its administration. This insures as high a proportion of oxygen as is desired. The apparatus is easily handled and assures adequate moisture to the inhaled oxygen. More than one patient can be treated at the same time with the same oxygen tank and the procedure is simple. Disadvantages of this method are: some discomfort to the patient, difficulty of keeping the catheter in position in a delirious or very restless patient and some waste of oxygen. The apparatus consists of an oxygen tank of sufficient size to allow flow of oxygen for some time. Small tanks demand frequent changes which may not be convenient and are relatively more expensive than the large tanks. Two gages are attached to the tank, one showing the tank pressure and the other showing the amount of oxygen flow. Attached to the latter is a metal tube which is porous or finely perforated at its free end to disperse more smoothly the oxygen passing through it. This tube is fitted into a quart glass jar so that the oxygen will bubble through water placed in the jar. There is an outlet through the tightly fitting lid of this container which allows the oxygen to pass through a tubing to the patient. An ordinary catheter is fitted to the end of this tubing and passed, after lubrication, through the nose of the patient into the oropharynx. After the proper depth of insertion is obtained, the catheter can be held in position over the nose and forehead by means of adhesive tape. Additional holes may be punctured about the inner end of the catheter to insure adequate flow of the oxygen. Care must be taken to avoid oxygen swallowing and subsequent dilatation of the stomach. The gages showing tank pressure and oxygen flow should be working properly to indicate the amount of oxygen given to the patient. This is especially valuable when the apparatus is handled by attendants under orders. There should be no overflow

which may cause discomfort and waste of oxygen. An insufficient flow may prove inadequate for the patient. The water jar should be kept properly filled so as to insure sufficient humidification and yet not permit flow of water to the patient or obstruct the tubing.

Oxygen may be administered by three other methods: (1) mask, (2) tent, (3) oxygen room.

Face masks may be used instead of a catheter on the apparatus described. This is less favorable than the intranasal catheter when a patient is restless because of the difficulty of keeping the mask tightly in position. For such patients, the oxygen tent and especially the air chamber are particularly useful.

The oxygen tent is another method of administering the gas, but it sometimes has an unfavorable psychologic effect on the patient. He may feel too confined. This method also may waste oxygen because of leakage and improper handling. It is cumbersome, a nuisance to the average attendant and a fire hazard. Means must be devised for proper cooling and humidification within the tent. Leakage may result in a low concentration of oxygen.

The ideal method, provided the oxygen need not be given under pressure or controlled breathing, is by means of an oxygen room or chamber. Unfortunately, this cannot be widely used because of expense. It is a satisfactory method for both patient and attendant and allows the treatment of more than one patient at a time.

THE PHYSICS OF OXYGEN THERAPY

The value of inhalations of 100 per cent oxygen lies in the substantial increase of oxygen in the blood stream. To effect this, the oxygen must reach the blood through the lungs. The diffusion of oxygen to the blood depends upon the number of capillaries in which blood is exposed to alveolar air, thickness of membranes and effectiveness of alveolar ventilation. According to Henry's Law the amount of oxygen absorbed by the blood depends upon the partial pressure of the oxygen in the lungs. Normally, the oxygen tension in alveolar air is greater than in venous blood. For this reason the diffusion of oxygen is from the lungs to the blood. The oxygen is then carried in simple plasma solution and in chemical combination with the blood. Ordinarily when oxygen in the arterial blood reaches the capillaries the oxygen tension is greater in the capillaries than in the tissues. Hense diffusion is to the tissues. More than fifty times as much oxygen is in combination with hemoglobin as in simple plasma solution, yet it is the oxygen of the plasma which diffuses because the pressure of the oxygen in the plasma determines the amount of permeation into the tissues. The corpuscles in turn replenish the plasma.

Other factors also play their part in aiding the diffusion of oxygen into the tissues. The carbon dioxide tension in the tissues is greater than in arterial blood. The difference in tension causes carbon dioxide to diffuse into the blood stream from the tissues. With resultant increased acidity the hemoglobin can hold less oxygen, thereby allowing more oxygen to pass easily into the tissues.

The amount of oxygen diffused to the tissues also depends on the rate of blood flow and the number of capillaries present. More diffusion occurs if the circulation is decreased. This is no advantage, however, because the partial pressure exerted by the oxygen in the capillaries may be markedly lowered as a result of decreased circulation.

Furthermore, a lowering of the oxygen content in the tissues, as after activity, causes more oxygen to diffuse from the blood. The heat produced also helps to free oxygen from the blood because of the increased metabolic rate. It has been shown that under such conditions as much as 80 per cent of the oxygen may be given to the tissues as compared with a normal percentage of about 40.

In the normal individual there is about 19.5 cubic centimeters of oxygen in 100 cubic centimeters of arterial blood. When 100 per cent oxygen is inhaled this amount is increased by 10 to 15 per cent. This increase is influenced by the efficiency of the apparatus intending to yield 100 per cent oxygen to the lung tissue and also by any disease of the respiratory tract which may interfere with the oxygen reaching the blood through the lungs.

Thus, the necessity of having or maintaining an adequate oxygen tension in the blood is apparent. The greater the oxygen tension in the blood the more oxygen will diffuse to the tissues and increase the oxygen tension there. It is evident that the administration of 100 per cent oxygen, or as nearly that percentage as possible, is the most direct method of increasing the oxygen pressure in the capillaries and tissue fluids.

CONCLUSIONS

Oxygen therapy is not necessarily meant to be treatment for the primary disorder. Its intended function is to relieve the anoxic or

anoxemic condition and thus the changes which have occurred as a result of the disease. It allows the patient to combat the primary condition more readily; and the burden on the heart and exhaustion are lessened. The success of any method of administration of oxygen depends upon early treatment, getting as much oxygen into the pulmonary alveoli as possible and continuing treatment a sufficient length of time. Treatment with oxygen should not be looked on as a last resort after all other measures have failed. It is a type of treatment that should be applied as early as possible in an effort to prevent or avoid serious complications. The efficacy of oxygen therapy is proportional to the day or minute it is started.

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OCCUPATIONAL CANCER

Occupational cancer is usually due to repeated irritation of skin or mucosa from substances used in industry. To reduce the rising incidence of occupational cancer, W. C. Hueper, M.D., writing in the J. A. M. A., suggests the following:

1. Plant management officials, industrial workers and members of the medical profession must be made increasingly aware of the fact that numerous agents of our industrial environment possess carcinogenic properties.

2. Engineers should design buildings, machinery and apparatus with this hazard in mind —that is, they should try to favor the closed system of production, installation of adequate exhaust ventilation, use of building material which does not absorb carcinogenic substances, avoidance of nooks, crevices and ledges where carcinogenic dust can be deposited, and employment of wall and floor covering that can be thoroughly and repeatedly cleaned with water and steam used in connection with cleansers.

3. Adequate provision must be made for removal of carcinogenic material from waste gas, fumes, waters, dust and the like before these waste products are released.

4. Whenever the use of carcinogenic material in industry cannot be eliminated workers should be protected from contact by suitable clothing, gloves, masks and the like and by the enforced observance of adequate hygienic measures, such as the use of washing facilities, showers and special rooms for storing street clothes and for taking meals and frequent changes of working clothes.

5. Frequent and experienced medical supervision of the workers exposed to carcinogenic material is imperative for effective control of the hazard. This supervision must also extend to workers who have left the employment after having been exposed to carcinogenic agents.

6. A nationwide survey by skilled investigators should be made to determine the actual scope of the problem of industrial cancer.

7. An institute for the study of industrial cancer should be founded and coordinated with one of the existing large cancer research centers.

8. A committee composed of industrial physicians, cancer research workers, industrial physicists, chemists and engineers, compensation lawyers, members of the Public Health Service and of state departments of industrial hygiene, representatives of industrial management and union officials should be created, whose members should act as a body of consultants and special experts of the Institute for the Study of Occupational Cancer.

ESOPHAGEAL HIATUS HERNIA *

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An esophageal hiatus hernia is a protrusion or herniation of the stomach, usually only the cardia, through the esophageal orifice of the diaphragm into the thorax. This type of diaphragmatic hernia, formerly considered very rare, is the most common form occurring in adults.

INCIDENCE

Statistics on the incidence of hiatus hernia in patients having roentgen study of the gastro-intestinal tract vary from .02 to 1 per cent, average being 0.25 per cent. With the more frequent roentgen examinations the incidence is naturally increasing, as shown by the many large series recorded in the past decade. Eppinger reports the necropsy incidence as 1.7 per cent.

In 7,500 gastro-intestinal roentgen examinations the writer has observed 51 cases of hiatus hernia, an incidence of 0.68 per cent. This has prompted the present report supplemented by a brief review of the important clinical and roentgen aspects of the condition.

Hiatus hernia usually occurs in middle or advanced age. It predominates in females, particularly in stout ones. In this series 96 per cent of the patients were more than 50 years old and the ratio of females to males was five to one.

The generally accepted classification of hiatus hernia is that proposed by Akerlund as follows:

1. *Congenital short esophagus* resulting in partial or complete thoracic stomach. This is a comparatively rare form, being a purely congenital anomaly and not a true hernia.
2. *Para-esophageal type,* in which the esophagus is of normal length and does not participate in the herniation of the stomach.
3. *Gastro-esophageal type,* the commonest form, in which both the lower end of the esophagus and stomach form the hernia.

ETIOLOGY

Many authorities believe that hiatus hernias are of congenital origin due to embryologic maldevelopment of the esophageal hiatus of the diaphragm. Others stress the acquired factors of relaxation of the hiatus as a result of increased intra-abdominal pressure and of weakness of the surrounding tissues, such as muscle and fat, incident to the degenerative changes of advancing age. Probably both congenital and acquired elements enter into the pathogenesis. Obesity is a definite contributory factor.

SYMPTOMS

Hiatus hernia may be symptomless especially in the small transient herniations. In the present series, seven cases, or 13.7 per cent, were asymptomatic. If present, symptoms are usually intermittent, the attacks lasting for a few minutes to several hours with varying periods of remission. The attacks characteristically occur on lying down after a large meal and, in typical cases, relief is obtained by standing, walking, belching or vomiting.

The symptoms are due to the disturbed function of the herniated stomach or of the organ encroached upon and thus may be either thoracic, abdominal or constitutional.

There may be a feeling of fullness in the chest especially after a heavy meal, occasionally associated with dyspnea, tachycardia and palpitation due to pressure on the heart. In many cases the patients complain of angina-like substernal or precordial pains with radiation to the left shoulder and arm simulating true anginal or coronary attacks. Dysphagia may be present due to spasm of or pressure on the esophagus.

Abdominal symptoms vary from vague epigastric distress to severe sharp pain radiating to the back and simulating cholecystic disease, especially when, as is usual, belching is associated. There may be heartburn and postprandial distress mimicking peptic ulcer.

The constitutional symptoms of weakness and pallor are the result of gastric hemorrhage incident to congestion or frank bleeding resulting from constriction of the stomach. Occa-

* Read at Annual Meeting, The Medical Society of New Jersey, May 22, 1946.

sionally gross hemorrhage manifested by hematemesis and melena results from an actual peptic ulcer in the herniated stomach.

DIAGNOSIS

The symptoms usually are not pathognomonic but occasionally suggest the condition by their occurrence on lying down after a heavy meal and relief on turning over in bed, standing or walking around.

Hiatus hernia notoriously simulates other diseases, notably cholecystitis, coronary heart disease, peptic ulcer and even carcinoma of the stomach. In this series, fourteen cases, or 27.4 per cent, simulated coronary heart disease; fifteen cases, or 29.4 per cent, were misdiagnosed as cholecystic disease; nine cases, or 17.6 per cent were thought to be peptic ulcer; and six cases, or 11.7 per cent, simulated carcinoma of the stomach.

On the other hand, the hiatus hernia may be purely coincidental and not the cause of the patient's symptoms. The latter, in these instances, are caused by ulcer, malignancy, cardiac or cholecystitic disease, as the case may be. It is therefore obvious that the role of hiatus hernia in a given case must be critically evaluated.

Polley found a high incidence of colonic diverticula in cases of hiatus hernia. This is not surprising in view of the frequency of both conditions in elderly stout people.

Physical examination is of little value in diagnosis. Occasionally a very large fixed hernia will give signs of tympany over the sternum changing to dullness on the filling of the stomach with food. The roentgen examination is the most important and, practically always, the only means of diagnosis.

ROENTGEN FINDINGS

Fluoroscopy in all positions including upright, prone, supine, the various oblique angles as well as the Trendelenburg, is essential. In the upright position before barium is given the gas bubble may occasionally be seen above the diaphragm in the fixed type of hernia resulting from adhesions or spasm.

After ingestion of the opaque meal, occasionally in the upright, but usually in the horizontal position, the hernia is seen as a round or oval shadow just above the diaphragm lying in or near the median line usually to the left of the esophagus. Obstruction on the lower end of the esophagus may be noted in large adherent hernias due to compression by the herniated mass and in some cases due to spasm or even stricture.

Other roentgen signs suggestive of the condition are an apparent decrease in the size of the stomach, displacement of the stomach to the mid-line, absence of the gas bubble in its usual position, retention of barium in the hiatus pouch above the diaphragm and restricted mobility of the left diaphragm.

In examining in the horizontal position, essential in most cases, it may be necessary to force the hernia through the hiatus by increasing the intra-abdominal pressure. Measures employed include deep inspiration, coughing, manual pressure or use of compression devices. The various types of hiatus hernias are often difficult to differentiate from each other but this is essential if surgery is contemplated.

In the *short esophagus* type the esophagus is straight and the hernia cannot be reduced on standing. Above the diaphragm are seen two slight constrictions between which is a dilatation characterized by fundal rugae and representing the portion of the stomach which has never been in the abdomen.

In the *para-esophageal* type the gas bubble is usually small and displaced to one side. The barium runs down the esophagus to below the diaphragm and fills the stomach. The latter appears to one side or around the lower esophagus, usually to the left and posterior, sometimes causing some compression on it.

In the *gastro-esophageal* type the cardio-esophagus junction is above the diaphragm when the stomach is herniated and the esophagus appears relaxed and tortuous. Gastric rugae are noted in the herniated pouch above the diaphragm and are characteristically contiguous with those of the portion of the stomach below, separated by the constriction at the hiatus.

Esophagoscopy is essential in helping to differentiate between congenital short esophagus and the true hiatus hernia and in the recogni-

tion of concomitant lesions in the lower end of the esophagus such as esophagitis, erosions, stricture, peptic ulcer or carcinoma.

Differential roentgen diagnosis is rarely difficult. Conditions to be considered are ampullary dilatation of the lower end of the esophagus, cardiospasm, esophageal or gastric diverticulum and eventration of the diaphragm. Rarely, conditions such as carcinoma, peptic ulcer or stricture of the esophagus may bear a superficial resemblance to hiatus hernia, but differentiation, aided by esophagoscopy, is usually simple.

As in any hernia, incarceration and strangulation may occur. Occasionally an ulcer at the junction of the esophagus and stomach, in the herniated pouch or in the constricted portion may perforate or bleed profusely as in peptic ulcer elsewhere. Usually the bleeding is due to congestion or erosion of the constricted portion of the stomach.

TREATMENT

Most cases are satisfactorily managed by medical measures, which are largely preventive or symptomatic. The object of treatment is to avoid overdistension of the stomach and to remove factors that are known to increase intra-abdominal pressure.

These aims are accomplished by: (1) Prescribing a diet of small, frequent bland feedings, low caloric in obesity; (2) avoidance of all causes of increased intra-abdominal pressure such as abdominal supports, girdles or corsets; strenuous exercise, especially lifting or bending; (3) relief of gaseous distension, coughing or constipation which may cause straining at stool; surgical removal of abdominal cysts or tumors; (4) instructing patients not to lie down immediately after eating and if distress occurs to get up and walk around for a few minutes; (5) sedative anti-spasmodic medication such as a combination of phenobarbital and belladonna, or synthetic substitutes, may be helpful in relieving symptoms. Supportative measures in the form of iron or vitamins are used judiciously as indicated; and (6) gastric hemorrhage and anemia due to erosions should be appropriately treated, and, if due to peptic ulcer, managed as is ulcer elsewhere.

Occasionally, operation will be indicated either to relieve an obstruction due to incarceration of the hernia or in cases manifesting a severe progressive course with intractability to medical treatment. Congenital short esophagus cases are not amenable to surgery.

Surgical mortality is high in the hands of the general surgeon with little or no experience with this condition. Harrington and Truesdale, however, report satisfactory results and a low mortality. Operative procedures include phrenicotomy either as a preliminary step to or as a substitute for the radical operation. The latter consists of the reduction and repair of the hernia through the thoracic or abdominal route.

SUMMARY OF DATA

Number of cases 51
Age of patients (45 to 77); average..... 63.5 years

	Number	Per Cent
Females	43	84.3
Males	8	15.7
Age over 50	49	96.0
Treated surgically	3	5.9
Condition asymptomatic	7	13.7
Simulating cardiac disease	14	27.4
Simulating cholecystic disease	15	29.4
Simulating peptic ulcer	9	17.6
Simulating carcinoma of stomach	6	11.7

SUMMARY

1. A series of 51 cases of esophageal hiatus hernia is reported, showing an average age of 63.5 years and a five to one ratio of females to males.

2. The symptoms of this condition simulated cardiac, gastric or cholecystic disease in 86 per cent of the cases. In 56 per cent of cases, the condition was misdiagnosed as either gall bladder or coronary heart disease.

3. The symptoms of hiatus hernia are not usually pathognomonic but diagnosis may be suggested in an elderly obese woman complaining of epigastric pain occurring on lying down after eating and characteristically relieved by change in position, usually by getting up and walking around.

4. Hiatus hernia should be considered a possibility in cases of unexplained anemia or in differential diagnosis of obscure cardiac and upper abdominal conditions that do not fit into a definite symptom complex.

5. Roentgen examination is the chief and

practically only method of diagnosis. Examination in all positions and particularly in the horizontal is essential. The important roentgen signs are described.

6. The treatment in most cases is medical, as follows: a diet of small, frequent bland feedings; correction of obesity; necessary antispasmodic, sedative, antacid, hematinic and vitamin medication; advice as to posture after eating; prevention and removal of all causes of increased intra-abdominal pressure such as the wearing of constricting abdominal supports, coughing, straining at stool, strenuous exercise and the surgical removal of intra-abdominal cysts and tumors.

7. Surgical treatment is only occasionally required and has given successful results with low mortality in the hands of surgeons with special training and wide experience in this condition.

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UNDULANT FEVER DIAGNOSIS OFTEN MISSED

Brucellosis, also known as undulant fever, is a difficult disease to diagnose because psychoneurosis may mask the original symptoms.

Writing in *The Journal of the American Medical Association,* Harris points out that "it is almost as easy to mistake psychoneurosis for brucellosis as it has been to commit the opposite error in the past, i. e. to diagnose actual brucellosis as psychoneurosis. The subjective complaints are likely to be very similar in the chronic illness."

Psychoneurosis usually develops because the disease is characterized by marked invalidism and slow convalescence.

The disease does not show characteristic symptoms and when the patient has persistent fever, sweating and complains of great fatigue and joint pains, there is reason to suspect the presence of an infectious disease such as typhoid or malaria.

Cows, hogs and goats harbor the Brucella bacteria and man contracts the infection by drinking raw milk or handling infectious material. The disease rate among veterinarians was 250 per 100,000. The only higher rate was among packing house workers, who had a rate of 271.5 per 100,000. By way of comparison, the rate for farm workers was 43 and for urban groups of merchant and professional men 3.3 per 100,000.

As far as is known, human beings do not directly transmit infection to other human beings, nor do they serve as reservoirs of infection for the indirect transmission of infection. The undiagnosed infection in the animal is almost limitless in its potential danger to other animals, and thence to man.

Treatment of brucellosis is likely to be a tedious, arduous task for both the physician and patient but is usually successful in bringing about recovery. Five years of freedom from all manifestations of illness probably should be the minimum period which must elapse before even the reasonable hope of cure should be entertained. Reports on cures after six months or less of observation, which are so frequently seen in the literature, are responsible for the perpetuation of many useless ideas about treatment.

In evaluating several treatment procedures the author contends that neither penicillin nor the sulfonamides give promise of being curative while streptomycin is only effective in terminating the acute illness. However, a relapse usually follows the use of this drug. A vaccine serves as the most effective treatment to date for the uncomplicated chronic infection.

CLARIFICATION

The theophyllin referred to on page 274 of the July 1946 issue of this JOURNAL for use in migraine is theophyllin-ethylenediamine.

GROUP PRACTICE: AN ANSWER TO STATE MEDICINE*

MAYNARD G. BENSLEY, M.D., Summit, N. J.

The physician who has an established practice is wondering and worrying if he will be able to continue as he is now doing or if he will be forced into an entirely different practice under government control, or under state or local political control.

There is no question but that some plan is going to be put in force, whereby low income patients will receive full medical and surgical care. Whether that plan will be government controlled, state controlled or medically controlled is up to the profession. At present there is no plan which the physicians of this country have devised which will answer the demands the public, the politicians or the government are going to make.

Most people want to pay their doctors. There are, of course, certain exceptions, but most people have respect for their physicians and wish to compensate them for services rendered. However, many of the low wage and middle class groups often find themselves suddenly burdened with a professional expense far beyond their ability to pay.

PREPAYMENT PLANS

Some form of prepayment plan will give those individuals an opportunity to have their medical bills paid and will give them a feeling of security, such as any of us, who carries a liability insurance policy on a car or an accident and health policy, may have. We know the hardship a prolonged illness or accident would cause in regard to our own ability to pay accumulating bills, if no income were being produced to care for such bills. Why shouldn't these low income people be given the same protection?

Prepayment medical care has already passed the experimental stage. It was definitely frowned upon, at its inception, by organized medicine, but public opinion, labor and the government have put the stamp of approval on this plan and, at last, the profession has begun to see its value.

Group medical practice can be the answer to these questions regarding the future practice of medicine. Groups are in a better position to adapt themselves to any plan of medical care distribution which may be thrust upon us, or which is developed within the profession, than is the individual physician. If necessary, they may do contract practice, have a health insurance plan of their own or have a combined group-hospital type of plan. The future success of a group is assured in any form of government, state or medically controlled plan.

ORGANIZATION OF GROUPS

Pooling of equipment from the offices of men getting together to start a group would furnish enough modern equipment to make it unnecessary to invest any real amount of capital for such material.

The group's offices should be under one roof and suitable for use of every doctor in the group. The common use of office space through adjustment of office hours makes possible greater economy in general overhead.

Some groups have all the professional personnel on salaries, with or without bonuses. Some have arrangements for drawing accounts. Some have a percentage overhead, the total income depending entirely on the amount of work done by the individual.

The operation of a group is described in several small booklets,† which are available.

ADVANTAGES TO THE DOCTOR

To a doctor affiliated with a group, the constant association and interchange of opinions with practitioners doing different types of work tend to increase the medical knowledge of each member of the group. Since no two men approach a problem the same way, the group affords the added stimulus of a fresh viewpoint. To the doctor, group practice offers the following advantages:

*Adapted from an article published in the May 1945 issue of the Bulletin of the Union County Medical Society.

† These include: *Group Medical Practice* by Committee on Research in Medical Economics; *Private Group Medical Service* by C. Rufus Rorem and John A. Musser; and *Group Practice* by the Summit Medical Group. The author will inform any interested reader how these pamphlets may be obtained.

1. Advance in medical knowledge, by closer association with medical personnel.
2. Time for post-graduate study.
3. Increased income.
4. Increased pleasure in professional effort.
5. Relief from bookkeeping and collection worries.
6. More regular life.
7. Full diagnostic and therapeutic equipment.
8. Time and facilities for research.

The equipment supplied by the group offers opportunity for the highest standard of practice. By sharing the cost of all expenses, including apparatus, the overhead is decidedly reduced. This is a distinct advantage to the group member wishing more diagnostic tests and more complete therapeutic equipment to treat certain of his patients, since this is prohibitive to most men practicing individually. An individual doctor's overhead is between 40 and 45 per cent of his gross income. In group practice, the overhead can be reduced to approximately 20 per cent. It is through this reduction in overhead that a group doctor's net income is materially increased.

The biggest problem to the individual doctor in these times is how to dispose of his detail problems, such as bookkeeping and collections. In group practice the physician is relieved of this responsibility by the business office, to such an extent that a doctor in the group can practice medicine exclusively and feel assured that a competent business office is satisfactorily handling all administrative procedures.

Group practice is a perfect medium to process the ever-growing methods of prepayment medicine. Since all branches of medicine are incorporated in one building, it is distinctly advantageous for any sponsored medical plan, whether nonprofit, commercial insurance company or governmental, to clear all such cases to the best interests of all. The increase in volume of work necessary under such a plan, perhaps at decreased fees, can better be handled through a group than by solo practice.

Prepayment plans will be a predominating factor in future methods of practice. Groups can handle such a method of practice to the best advantage. Groups may also arrange for contracts among self-employed persons and others who are not eligible for the usual types of prepayment plans.

ADVANTAGES TO THE PATIENT

If group practice were advantageous only to the doctor, it could not for that reason alone be justified, since after all, our major obligation is to the patient. However, group practice carries many advantages for the patient too. Among them are:

1. More complete medical service, with less inconvenience to the patient.
2. Saving in time and travel.
3. Decreased cost.
4. Confidence through strength in organization.
5. More satisfactory business relations and better public relations through an efficient business office.
6. A doctor always on call and available.
7. Complete examinations possible in one building.
8. Correlation of findings through consultations.
9. Group ready for any emergency.

The public takes rapidly to the group idea, because it is conscious that in organization there is strength. People go to a group because they know that they will find there someone who has been trained in the care of their particular problem.

Combined services make it unnecessary for the patient to travel about from one place to another for special opinions or laboratory examinations. The patient is further protected because the original physician maintains his interest in the progress of the case at all times.

Patients maintain their individual physician relationship, but, in addition, have available other specially trained members of the profession supporting that individual physician. And the fact that there are always doctors on call, ready for any emergency, gives added confidence and comfort to the patient.

Improvement in the quality of the care rendered to the patient results directly from this coordination of personnel and facilities.

PERSONNEL OF THE GROUP

A group may be developed wherever two or more physicians are located. By combining the equipment and skills of each individual, an organization is formed which can give better service to the community yet which can provide a more efficient, more profitable and less exhausting program for each individual doctor. The expenses of the individual members

of the group are reduced because they share expenses for light, heat, rent, nurses, secretaries, technicians, books, phone-operators and other overhead items.

A group need not be composed entirely of specialists. The general practitioner may continue his duties indefinitely, knowing that he has at his command the services of specialists wherever the need arises. If a physician is doing general practice in an outlying district, he may continue his local work, but maintain relations with a group, where he has available equipment for diagnostic and therapeutic aid, as well as consultation service. He may do part time work with the group, along general lines or special work in that branch of medicine in which he is especially interested.

Small groups may be affiliated with larger groups in order to avail themselves of the added equipment and more specialized physicians in a larger group. Thus, a small group would be unlikely to number in its personnel a brain surgeon, who would, of necessity, be on the staff of a much larger group.

Group practice is especially attractive to the younger man, as he can start in practice at no great expense to himself. He does not have to invest in new office quarters or expensive equipment. He is assured of work at the start, if not of his own, by the support of the more active of his associates in the group.

The same is true for the man returning from duty with the armed forces. Those in the service who are members of the group with which I am associated have frequently written stating how thankful they are to know that on their return they will have a secure position and can immediately get back into civilian practice, with no thought as to the necessity of refurnishing offices, getting equipment out of storage or new equipment for perhaps a new line of work. They will be absorbed into the group, where a great part of their former practice has been held for them, and they will not have the struggle and fight to regain their former status, as will those destined to return to a closed office and a practice scattered to the four winds.

In the Army or Navy, medical officers practiced group medicine no matter where they were assigned. There was no solo practice, and the medical officer was happy to have at his disposal the equipment, instruments, and consultants which made team work possible. This experience is going to mold their opinions and make them want to continue this type of practice in civilian life.

THE INDIVIDUALIST

Some physicians, particularly older ones who have been in private practice for years, say that they would not be happy working in a group. They boast of their individualism. Yet most of them have worked on hospital staffs with other doctors; perhaps not always with the greatest amount of harmony; still, some of these same physicians cannot always get along with their families, but they are far happier with their own families than they would be if they were living alone. These men could, with little effort, adapt themselves to group practice. Solo practice may be all right for some, but, really, only for a small minority. The vast majority are much happier working and living with others.

COMMENT

New groups formed now, and it can be done now in most communities even where groups happen to be functioning, can provide an excellent opportunity to absorb men who will, in the not too distant future, return to their homes and civilian practice.

This paper is based on an experience of 25 years of group practice, starting with two men and growing to an organization of eighteen doctors, with an employed personnel of 32. There has been a steady growth, in spite of several national financial depressions and in spite of, at first, critical opposition by fellow members of the profession.

It is my belief that the formation of groups throughout the country will be the answer to the demands of the public for the best of medicine at a price they can afford to pay, that it can forestall government intervention in the practice of medicine, increase the quality of medicine offered, promote scientific research and be completely controlled by the medical profession.

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TREATMENT OF CARCINOMA OF THE RECTUM *

By Damon B. Pfeiffer, M.D., Abington, Pa.

Carcinoma of the rectum carries a more favorable prognosis for arrest than does carcinoma of any other major internal organ. However, it is still a cancer. Some day we may cure cancer with intravenous injections, but until then surgery and radiation are our mainstays. X-ray and radium treatment for carcinoma of the rectum, in my experience, have not been successful. The lesion is an adenocarcinoma almost without exception. The cells are well differentiated, grow slowly, and some of them may even possess normal functions such as the secretion of mucus. One should not expect radiation treatment to be effective in these circumstances. Our method of treatment then, is surgical extirpation of the lesion, performed in such a way that the requirements of cancer surgery are fulfilled. In operating for cancer, the surgeon must (1) remove the lesion along with (2) a generous portion of normal tissue on all sides of the growth, and (3) he must remove the areas of lymphatic spread. Any operation which fails to meet these requirements fails also to give the patient the hope of cure he has a right to expect.

ANATOMIC AND PHYSIOLOGIC CONSIDERATIONS

In the rectum, there are four anatomic and physiologic factors which directly influence the surgical approach.

(A) *The rectum is inaccessible.* While the rectum itself can often be removed by a perineal approach, complete removal through an abdominal incision is almost impossible. Therefore, if an abdominal incision is required to remove lymphatic zones of spread which cannot be reached from below, a combined abdomino-perineal operation must be done. Such an operation is extensive and requires special surgical skill.

(B) *The blood supply to the rectum is relatively poor.* Since the rectum functions only as a storage reservoir where a little absorption takes place, it does not require the rich vascular supply common to the upper gastro-intestinal tract. When the operator removes a portion of rectum and then performs an anastomosis, this relatively poor blood supply becomes a factor which may determine the success or failure of the operation and the life or death of the patient.

(C) *The lymphatic drainage of the rectum is of vital importance* for the future of the patient. We are dealing with cancer and we must not only remove the growth, but in addition we must remove every zone of lymphatic spread.

Foundations for radical rectal surgery were laid down 36 years ago by W. E. Miles of London. He found that lymphatic spread occurred in three directions: upward along the root of the mesentery; laterally to the peri-rectal tissues; and downward along the inferior hemorrhoidal lymphatics. Miles introduced the combined abdomino-perineal operation, a procedure which meets the requirements of cancer surgery by removing the growth plus all the zones of lymphatic spread. Recent investigation by Glover and Waugh [1] indicates that when the carcinoma lies in the upper portion of the rectum, the upward zone of spread is the one followed by lymphatic extension until lymphatic blockage occurs; then retrograde downward spread takes place. Such downward spread was found in only one per cent of cases. Studies of this sort lend credence to the growing belief that anterior resection and anastomosis is a safe and desirable procedure for carcinoma of the upper rectum.

(D) *The rectal contents are always infected.* When an ulcerated carcinoma is present, the number of virulent organisms increases. The fecal materials in the rectum are solid or semi-solid as compared to the liquid bowel contents higher in the intestinal tract. Two hazards to surgery are thus present: infection from contaminated rectal contents and, if an anastomosis is made, trauma to the suture line unless the fecal stream is diverted.

Many improvements in surgical treatment have developed since Miles introduced the abdomino-perineal operation. During the operation itself, the de Martell clamp shortens the

* Read on May 22, 1946, before Annual Meeting of The Medical Society of New Jersey.

1. Glover, R. P., and Waugh, J. M.: The retrograde lymphatic spread of carcinoma of the rectosigmoid region. S. G. O., 82:434, 1946.

operating time somewhat; continuous spinal anesthesia provides adequate, safe relaxation, and the giving of transfusions and intravenous electrolytes helps to prevent shock. In the preoperative stage, the giving of sulfasuxidine improves the local bowel preparation of patients, and administration of vitamins and amino acids by vein improves their general condition. Postoperatively, the figure-of-eight wire suture introduced by Smead at Jones' clinic helps prevent wound infection, and the antibiotics available to us now (sulfa drugs and penicillin) are invaluable in controlling pulmonary infections. Should a break in technic occur, the preoperative use of sulfasuxidine minimizes somewhat the threat of peritonitis. Thus, there are improvements in the various surgical adjuncts. Coming back to fundamentals, we see that the character of the fecal stream has been improved, but the rectum is still relatively inaccessible, its blood supply remains precarious, and a thorough operation still includes removal of the upward zone of lymphatic drainage in all cases as well as the lateral and downward zones of lesions of the mid-rectum and lower rectum.

RESULTS OF OPERATION

Let us review the known results from the abdomino-perineal operation which represents standard treatment today for rectal carcinoma. My own experience comprises 177 patients with carcinoma of the rectum at the Lankenau Hospital alone. Six refused operation, leaving 171 patients who were candidates for treatment. Gross operability was 89 per cent. Abdomino-perineal resection was performed in 51 per cent of cases with a mortality of 8 per cent for the one-stage procedure. Of these patients who had the abdomino-perineal operation, 45 per cent are living, well, and free of cancer for five or more years. Seven per cent died of other illnesses five or more years after operation and were free of cancer at that time. The so-called "salvage rate" in my hands, then, is 52 per cent of patients upon whom I have performed an abdomino-perineal operation and 28 per cent of all patients with rectal cancer whom I have seen. These results are not unusual. Similar figures are reported by other men familiar with this operation. I think it is only fair to ask that operations now being performed in the hope of relieving a patient from rectal cancer without giving him a colostomy should be productive of a comparable salvage rate.

THE KRASKE OPERATION

About 50 years ago, Paul Kraske, a German surgeon, removed the coccyx and the left wing of the sacrum to gain access to the rectum and the growth it contained. He excised the growth and a section of bowel. Attempts at reëstablishment of continuity were seldom successful. Usually the upper end of the bowel was brought out the wound where it became a permanent colostomy. The Kraske operation and its numerous modifications were all open to two objections: (1) they were incomplete procedures in that the upward zone of lymphatic spread was not removed, and (2) they allowed patients to be hag ridden by a colostomy in an inconvenient spot. Only recently, the Kraske operation has been revived.[2] Restoration of continuity was successful and fourteen of the fifteen patients reported had normal bowel movements without persistence of a posterior fistula. Not enough time has elapsed to determine the ratio of patients who will die of recurrence. To my mind, this sort of surgery is comparable to removing the lump in cases of breast carcinoma. In appraising such a procedure, we must never lose sight of the most important reason for surgery, which is cure of the patient. The enthusiasm over avoiding colostomy is justified only if the patient will live as long without a colostomy as with one.

THE HOCHENGG OPERATION

Another development which is not new, but has recently come into prominence, is the modification of the Hochengg "pull through" operation. Here the abdominal dissection is roughly comparable to the Miles operation. A limited perineal procedure is then carried out, preserving the rectal sphincters. The bowel is then drawn down through the sphincters and the growth plus some bowel above it are excised. The upward zone of spread is fairly well re-

2. Murray, Gordon: Resection of the rectum with reconstruction of canal through the perineal approach. S. G. O., 82:283, 1946.

moved. The lateral and downward zones are not removed. The procedure has for its object a resection said to be comparable to the abdomino-perineal operation plus restoration of a functional anus. In addition to the reason suggested, I do not use the operation for three further reasons. First, patients I have seen upon whom this procedure was performed, did not have a normally functioning anus. Instead, they had a perineal colostomy, inaccessible, located in a hairy area, with no control. Inability to regulate the colostomy required the wearing of a diaper and was attended by offensive odor and considerable inconvenience. Second, for lesions high in the recto-sigmoid, I see no advantage in this operation over anterior resection and anastomosis. Since the lateral and inferior zones of lymphatic spread are not removed by either procedure, one might as well spare the patient a perineal dissection. Third, in low lying growths, the operation has little more merit than the Kraske procedure, and in this type of growth I firmly believe that only the abdomino-perineal operation can offer the patient a reasonable hope of cure.

ANTERIOR ANASTOMOSIS

The third type of operation which has recently come into greater prominence is anterior resection and anastomosis. It has been used in the left colon, the sigmoid, and even in the rectum within a few centimeters of the anus. Formerly it was preceded by or accompanied by proximal colostomy. Today, many surgeons perform the operation without any form of proximal decompression except perhaps the Miller-Abbott tube. As applied to the rectum, anterior resections have now been done with low mortality and morbidity rates. The operation is desirable in the regions of the splenic flexure, descending colon, sigmoid, and early lesions of the upper rectum. In these cases, the upward zone of spread can be removed just as well as in the abdomino-perineal operation. However, in rectal carcinoma at or below the peritoneal reflection, the anterior resection will not cure enough patients to justify its use. Also, in relatively late lesions of the upper rectum where lymphatic blockage has occurred and retrograde lymphatic spread should be anticipated, I believe that anterior resection is an inadequate procedure.

PROXIMAL COLOSTOMY

Consideration should also be given to proximal decompression. Throughout my life in surgery, I have seen the subject of colon resection and anastomosis without proximal decompression revived and dropped and then revived again only to be dropped once more because of leakage and a consequent high mortality rate. These days, surgeons can operate on colons and rectums which are cleaner than they have been in the past, and the mortality of primary closure without proximal decompression should naturally be less than in former days. But, in cancer surgery there is a time to be radical, and in this particular type of cancer surgery there is also a time to be safe. In the removal of the growth and zones of spread, the operation should be as radical as the skill and heart of the surgeon can make it. Once the growth and zones of spread have been removed, every precaution should be taken to make the procedure safe. In the light of this viewpoint, I do not see how we can avoid the making of a proximal colostomy. I believe every surgeon who loses a patient in whom a proximal colostomy was not made should take counsel with himself and honestly try to decide whether the patient might have lived if proximal decompression had been instituted. These colostomies, of course, are temporary. True, they add two to four weeks to the convalescent period, and closing them is a minor operation. But let us remember we are dealing with cancer which gives us only one chance. A dozen extra weeks and several operations are justified if they increase the hope of cure. Formerly, I would explore these patients and then make a temporary colostomy. Two weeks later, I would resect the growth and perform an anastomosis. Two weeks thereafter I would close the colostomy. Since improved methods of colon preparation have been developed, I now perform the colostomy at the time of resection. I am not willing to dispense with colostomy, however, or replace it with cecostomy or the Miller-Abbott tube. And for reasons I have mentioned, I do not regard anterior

resection as a suitable cancer operation when the growth is at or below the peritoneal reflection.

The pendulum has swung far in the direction of operations designed to avoid colostomy and remove a rectal carcinoma. As a surgeon who has worked with the problem of rectal carcinoma in all my professional life, I welcome this opportunity to reëmphasize the fundamentals of rectal surgery and to hold up the results of the abdomino-perineal operation as a yardstick with which the other procedures must be measured.

When colostomy was performed as the only operation for rectal cancer or when it was done in the vain hope of relieving future obstruction, it was naturally regarded as an evil. However, I cannot understand the widespread abhorence of colostomy when it is done for a patient whose growth has been removed and who has been freed of carcinoma. That abhorence I mention seems a very near cousin to the persistent reluctance of many physicians to perform rectal examinations. Let us look at the question of colostomy from another viewpoint, that of the patients. Eight years ago, when we appraised our results, we found six patients who refused operation because of the horror of a colostomy. Today the number is still six. The reason is that when a patient hesitates to consent to operation because he fears colostomy, we telephone one of our friends who has been operated upon, and he comes to the hospital to talk to the patient who must make the decision. Patients must, of course, be taught to manage their colostomies, and we regard this instruction as one of our important duties. In a word, a colostomy must be well made, well placed, and well managed. Then patients will live normal lives even with an artificial stoma. The time has passed when we must apologize for colostomies. Doctors and nurses who work with me and see the end results many years after operation often come to me and tell me they have been convinced. Objections to colostomy vary in inverse proportion to knowledge of colostomies.

York and Woodland Roads

SURGICAL RISK IN PYLORIC STENOSIS

Operative risks for infants, suffering from a tumor obstruction at the opening of the stomach, are fast declining, according to three physicians from the Harvard Medical School, Boston.

The doctors, writing in the June 22 issue of *The Journal of the American Medical Association,* are: William E. Ladd, Paul F. Ware, Lawrence K. Pickett.

The article states that 1,145 patients with pyloric stenosis have been operated on by the Surgical Service of the Children's Hospital since 1915 with a death rate of 40. "In the past three and one-half years 225 consecutive cases of pyloric stenosis have been treated surgically without a fatality."

Pyloric stenosis predominates in males. The physicians state that "approximately 85 per cent of the cases occurred in male infants" in their hospital. The condition occurs most frequently in the first born of a family, averaging 50 to 60 per cent of cases in most series. "Our own figures bear this out," they state, "as our patients represented first births in approximately 55 per cent of cases." Heredity is another predisposing factor. "Families with the disease present in several siblings or found in successive generations are not infrequent."

The symptoms which usually appear from the second to the fourth week are reduction of water in the tissues, vomiting after each feeding and loss of weight. Also, the tumor can usually be felt as a firm, hard, freely movable body, to the right of the naval and a little above it. Diagnosis should be made as soon as possible with x-rays. Persistent vomiting should be immediately investigated for if the condition continues without relief by surgery, death soon will ensue.

The authors conclude that the operation, done promptly by a skilled, experienced surgeon, preceded and followed by proper management, will result in cure in almost everyone.

STATE ACTIVITIES

WELFARE COMMITTEE

The Welfare Committee met at 2:00 p. m., Sunday, September 15, 1946. at the headquarters of The Medical Society of New Jersey in Trenton. The following members of the committee were present:

Allman, D. B. (Atlantic)
Blaugrund, S. (Mercer)
Butler, V. P. (Hudson)
Cherry, H. H. (Passaic)
D'Arcy, W. E. (Mercer)
Giordano, S. (Morris)
Guion, E. H. (Atlantic)
Heller, G. (Bergen)
Hurff, J. W. (Essex)
Jack, H. W. (Camden)
Jehl, J. R. (Passaic)
Morris, W. B. (Union)
Mulligan, L. A. (Bergen)
Murphy, H. S. (Union)
Murray, H. A. (Essex)
Nichols, S. (Monmouth)
Pollak, B. S. (Hudson)
Pratt, A. G. (Camden)
Read, H. S. (Chairman)
Schellenger, E. A. (Camden)
Sica, L. S. (Mercer)
Ulmer, C. I. (Gloucester)
Varney, W. H. (Warren)

Also present were the following guests, officers or members of subcommittees:

C. F. Church
H. A. Davidson
J. Debus
E. P. Duffy
S. W. Esty
W. G. Guthrie
W. K. Harryman
J. O. Hill
A. E. Jaffin
S. W. Kalb
J. G. Kaufman
S. J. Lloyd
J. F. Londrigan
W. H. MacDonald
R. A. MacKenzie
W. J. Marquis
C. E. McNenney
F. J. Quigley
W. L. Rumsey, Jr.
R. A. Schaaf
N. M. Scott
H. F. Tidwell
H. T. Weiner
E. L. Wood
A. Yaguda
E. T. Yorke

Dr. Hilton S. Read, Chairman of the Welfare Committee, presided and called the meeting to order at 2:00 p. m. Chairman Read served as a delegate to the American Medical Association in San Francisco and gave a brief summary of the activities of the House of Delegates at that meeting. The Welfare Committee then received and accepted the reports of its subcommittees as follows:

Subcommittee on Legislation. Report read by Dr. Frederic J. Quigley and printed on page 426 of this Journal.

Subcommittee on Public Health. Report read by Dr. Samuel Blaugrund and printed on page 428 of this Journal.

Subcommittee on Public Relations. Report read by Dr. L. S. Sica and printed on page 430 of this Journal.

Subcommittee on Medical Practice. Report read by Dr. Watson B. Morris and printed on page 432 of this Journal.

Chairman Read officially notified the Welfare Committee of the death of Dr. Wells P. Eagleton, first chairman of that committee and Senior Fellow of The Medical Society of New Jersey. Dr. Read's remarks were as follows:

"With a heavy heart I am sure, all of us have heard of the death of Dr. Eagleton. Dr. Eagleton was the founder and first chairman of this committee. We have not always seen eye to eye with him, but I think all of us could say that his intentions were always honorable, his energy endless and his hopes eternal for The Medical Society of New Jersey. I would like to read an editorial which Dr. Quigley just handed me from the September 15 issue of the Newark *Sunday Call:*

"Dr. Wells P. Eagleton's life was rich and good and his carcer was full of achievement and renown. His was a brilliant intellect and his contributions to medical knowledge made his name honored throughout his profession.

"Transcending perhaps even his distinction as a surgeon and scientist was his love for his fellow men. His charity had depth and sincerity and led him far beyond formal philanthropy into many acts of generosity and kindness and made him a determined and outspoken champion of the oppressed and underprivileged.

"Politically he was left of center and a firm supporter of President Roosevelt and the New Deal. He made no secret of his sympathies and enjoyed his frequent spirited conflicts with conservative professional and business associates.

"For all who suffered he had warm sympathy and put at their service all his skill and, often, his material resources. No worthy call upon his time and talent went unanswered. The prayers of grateful thousands follow him to his grave."

At the conclusion of the reading of the editorial and at the request of Chairman Read. all present stood for a moment of silence in tribute to the memory of Dr. Eagleton.

The Welfare Committee received the report of the *Veterans Liaison Committee* which was read by Dr. Londrigan and is printed on page 441 of this Journal.

Dr. H. S. Murphy reminded the committee

that the Medical Society of the State of New York is preparing a new edition of its useful "Tristate Directory". In the past, our members have been able to buy this directory through The Medical Society of New Jersey at a reduced rate made possible by the fact that our Society bought copies in bulk from the New York Society. On Dr. Murphy's motion, the Welfare Committee recommended that the Board of Trustees authorize purchase of new issues of the "Tristate Directory" in bulk from the Medical Society of New York.†

There being no further business, the committee adjourned at 3:50 p. m.

SUBCOMMITTEE ON LEGISLATION

Report to Welfare Committee, September 15, 1946

In the Federal Legislative Bulletin of August 22, which was mailed to all members of the Welfare Committee,* and to its Subcommittees and Advisory Committees, mention was made of the disposition of the important measures of medical and public health interest introduced in the 79th Congress. Two of these measures: S. 2143, National Health Act, introduced by Senators Taft of Ohio, Smith of New Jersey and Ball of Minnesota, and H. R. 1362, amendments to the Railroad Retirement Act, providing for cash sickness and maternity benefits, deserve more extended explanation and comment than is practicable in a legislative bulletin.

Two other happenings occurred while the 79th Congress was in session of such importance as to warrant consideration and comment. We refer to the reorganization of the Executive Department of the federal government and the provisions of the agreement of May 29, 1946, between the United States Government and John L. Lewis' union in settlement of the bituminous coal strike which establish (a) a Welfare and Retirement Fund and (b) a Medical and Hospital Fund.

REORGANIZATION OF THE EXECUTIVE DEPARTMENT

Pursuant to authority of the Reorganization Act, passed in 1945, President Truman, on May 16, 1946, transmitted to the Senate and the House three plans of reorganization. Plan No. 2 is the one with which we are especially concerned.

Under this plan the Children's Bureau was amputated from the Department of Labor and placed in the Federal Security Agency. This is the present residence also of the Public Health Service. The functions of the Social Security Board were transferred to this agency, as well as those of the U. S. Employees Compensation Commission, the Assistant Commissioner of Education and the Federal Board for Vocational Education, among others. We think it plain to all that the Federal Security Agency is a welfare agency and not a public health agency.

At the hearing on Plan No. 2, before a Committee of the House of Representatives, Dr. Sensenich, Chairman of the Board of Trustees of the A. M. A., said, "It is the opinion of the Board of Trustees that health activities of the Government . . . should not be subservient to any other departmental interest." However, he related that a resolution was adopted by the House of Delegates at the 1945 meeting which recommended that the health services of the "Children's Bureau of the U. S. Department of Labor should be transferred to the Federal Security Agency until such time as the Congress creates a National Department of Health with a qualified physician as its director, with Cabinet status". With this mandate from the House of Delegates it seems clear that Dr. Sensenich was obliged to record approval of Plan No. 2. What animated the House of Delegates to take this action we do not know. If the House of Delegates had not taken such action it would seem that this was the appropriate time to have registered strong disapproval of the placing of health activities of the Federal Government into a welfare agency, and to advance arguments in support of the position held by organized medicine for forty years of the desirability and need of establishing a Federal Department of Health. Instead, now, with the approval of Reorganization Plan No. 2, we have the Children's Bureau and the Public Health Service in this welfare agency, together with all the social security functions of the government.

Shortly after the President had projected his Reorganization Plan No. 2 the newspapers carried a dispatch that Miss Lenroot, Chief of the Children's Bureau, stated that she had been assured by the President that the present activities of the Children's Bureau would not be interfered with, after placing it in the Federal Security Agency.

Mention should be made of an interesting section of Reorganization Plan No. 2. Section 5 states, "In addition to the Assistant Federal

* And reprinted on page 434 of this JOURNAL.
† See bottom of page 436, this JOURNAL.

Security Administrator there shall be, not to exceed two, *assistant heads* of the Federal Security Agency . . . at the rate of $10,000 per annum. . . ." Would it be considered a prophecy to suggest the likelihood of Miss Lenroot's appointment as one of the assistant heads of the Federal Security Agency! The only vacant place in the Federal Security Agency would appear to be that reserved for the subdepartment on "Compulsory Health Insurance".

Reorganization Plan No. 2 failed of approval by the House and was approved by the Senate only by a very close vote. If organized medicine had opposed this plan it might have failed of approval. Plans for reorganization of the Executive Department become operative unless *both* Houses register disapproval within sixty days of the date of submission of plans.

MINE UNION FUND

The provisions of the agreement of May 29, 1946, between the United States Government and John L. Lewis' union in settlement of the bituminous coal strike which established (a) a Welfare and Retirement Fund and (b) a Medical and Hospital Fund, include the following:

(a) *Welfare and Retirement Fund*—This fund shall be administered by three trustees: one appointed by the Coal Mines' Administrator, one appointed by the President of the United Mine Workers (John L. Lewis) and the third chosen by the other two. There is paid into this fund 5 cents on each ton of coal produced. Incidentally we have been informed that in the first six weeks this fund was in operation thirty million dollars were paid into it. The purposes for which this fund may be spent are broad. It may be used to augment workmen's compensation payments when deemed inadequate, for cash sickness payments, permanent disability, death, or retirement.

(b) *Medical and Hospital Fund*—This is to be administered by trustees appointed by the President of the United Mine Workers (John L. Lewis), and is to be accumulated by deductions from wages as authorized by the union for medical, hospital and related purposes. The Navy at present is operating the mines for the Government. A survey by the Medical Department of the Navy is under way, and recommendations will be made, as we understand it, as to sanitary conditions and methods by which medical and hospital services can be improved. It seems obvious that the agreement between such a strong union as the United Mine Workers and the Government, as to control of medical and hospital services, by such a large segment of labor, will have a profound effect upon all of organized labor.

NATIONAL HEALTH ACT

The action by the House of Delegates of the A. M. A., at its 1946 meeting, authorized the Council on Medical Service and Public Relations and the Bureau of Legal Medicine and Legislation "to confer with the sponsors of S. 2143 to discuss the features of said bill", makes it very likely that a bill conforming to the principles of this measure, with provisions agreeable to organized medicine, may receive the support of the A. M. A. Regardless of this, our information at the moment leads us to believe that a counterpart of S. 1606, the Wagner-Murray-Dingell Bill, will be reintroduced.

Inasmuch as one of the sponsors of S. 2143, Senator Smith, is from our own state, we believe that a conference with Senator Smith and representatives of The Medical Society of New Jersey will be helpful at this juncture. To this end President-Elect Schaaf, at the direction of President Scammell, is endeavoring to arrange such a conference with Senator Smith for an interchange of views. Senator Hawkes, of course, will also be invited.

RAILROAD RETIREMENT AND UNEMPLOYMENT INSURANCE ACTS

The amendments, which are now law (Public Law 573), provide for cash sickness and maternity benefits to beneficiaries of the act. The A. M. A. took no action with respect to this bill. This attitude presumably was dictated by the action of the House of Delegates at a special session in 1938 and reaffirmed by the House of Delegates at the 1946 session, recording its approval of *the principle* of cash sickness benefits. Approval of the principle of cash sickness benefits at these two sessions of the House of Delegates of the A. M. A. did not necessarily favor payments of cash sickness benefits by the Federal Government. The argument that it would be impossible to make provision for cash sickness benefits to railroad employees except through federal legislation inasmuch as this class of workers is engaged in interstate commerce may be valid. However, we are not convinced that this class of workers, as well as any other worker, could not be provided for through *state* cash sickness benefit plans.

It would seem to us, opposed as we are to the federalization of medicine, that we should be opposed in principle to cash sickness benefits by the Federal Government. Does not this provide a precedent and an incentive to other labor groups to seek legislation which would provide these benefits by the Federal Government?

MEDICAL PRACTICE BY LABORATORIES

The Welfare Committee at its last meeting referred to the Subcommittee on Legislation the problem of the interpretation of section 45:9-18 of the Medical Practice Act with reference to the activities of laboratories not directed by licensed physicians. The Subcommittee has sought the opinion of counsel and this is presented below. It is recommended

that the matter be referred to the State Board of Medical Examiners which is the agency in charge of enforcement of the Act for interpretation and comment. The following letter from Wall, Haight, Carey and Hartpence, the Society's counsel, is self-explanatory:

Dear Doctor Quigley:

This letter is in reply to your letter of August 23rd, in connection with an interpretation of Section 45:9-18 of the Medical Practice Act.

Persons who work in laboratories and who have no medical degree and perform merely the mechanics of the various laboratory analyses under the supervision of a practicing physician are exempt from the provisions of the statute. This is necessarily so, since we imagine that there are a great many mechanical steps which must be taken in any given analysis, to which the doctor himself could not devote the time. The public, however, is safeguarded by reason of the supervision exercised by the doctor over his assistants' findings.

Under a strict interpretation of the statute, a non-licensed person, to be held guilty of a violation of the statute, would have to do two things: (1) use some designation or title which would represent or imply that he is a medical practitioner, and (2) diagnose . . . or offer or undertake to diagnose . . . any disease or physical condition. This would not bring under its condemnation any person who did not affect the use of a title. As we interpret the Act, a person known only as John Smith could do all of the acts prescribed by the statute without being guilty of any violation, since the first condition laid down by the statute has not been fulfilled (i.e., the usurpation of some title). We are inclined to the belief that a court, in order to effect the true intent of the statute, might override the strict meaning of the words used and hold that John Smith was guilty of a violation. However, an ambiguity most certainly is present, and we would recommend that the statute be amended so as to apply in terms to any person, whether he use a title or not, who holds himself out or who offers or undertakes by any means to diagnose, etc.

We trust that we have answered the particular question which is concerning you at this time. If not, we shall, upon request, endeavor to be more explicit.

Very truly yours,
Wall, Haight, Carey & Hartpence.

PENDING LEGISLATION

It is idle to speculate at this time on what type of legislation we will be compelled to handle in the 1947 session of the State Legislature. The only subject which we feel sure will receive consideration is legislation to provide for cash sickness benefit allowances. In view of the attitude of the State Commission on Post War Economic Welfare with respect to this subject, which has been previously reported, we believe that such legislation, if passed, will be in accord with principles which this Society can endorse.

B. S. Pollak, M.D., Chairman.

SUBCOMMITTEE ON PUBLIC HEALTH

Report to Welfare Committee, September 15, 1946

The Public Health Subcommittee met with representatives of other interested agencies and offers the following report, touching on eight phases of its work: (1) child health, (2) school health, (3) mental hygiene, (4) crippled children, (5) tuberculosis, (6) cancer, (7) venereal disease and (8) maternal welfare.

CHILD HEALTH

In the field of child health, five recommendations are made: (1) education of all physicians as to the importance and details of the rheumatic fever program, (2) corresponding education of the general public, (3) establishment of more cardiac clinics in hospitals in New Jersey, (4) the addition of nursery schools to the school system of this state, and (5) conferences with related organizations for the purpose of improving school health and drafting the necessary changes in the law. The following agencies should be invited to such conferences:

Department of Education, State of New Jersey
Department of Health, State of New Jersey
New Jersey Dental Association
The school nurses and school physicians
State Teachers Association
New Jersey Education Association
School Health Committee of The Medical Society of N. J.

SCHOOL HEALTH

Our recommendations in this area are as follows:

1. Get away from routine physical examinations.
2. Suggest child be examined when entering school for first time entirely stripped.
3. Other examinations should be made after screening of children through observation by teachers and conference with school nurse. They would decide which children should be examined and appointments for such examinations made with school physician.
4. Suggest School Health Day—teachers to be made health conscious—and other additional features in the school health program.

MENTAL HYGIENE

Analysis of problems of mental hygiene resulted in the presentation of four recommendations and three further goals. The recommendations are:

1. Programs of education for school physicians, nurses and the PTA on mental hygiene and child psychiatry.
2. Circularize material on mental hygiene and child psychiatry to school physicians, nurses and teachers.
3. Circularize list of mental hygiene clinics and private psychiatric facilities.
4. Development of classes for retarded and problem children.

Further goals are:

1. Psychologic and psychiatric examination and treatment of as many retarded and problem children as possible.
2. Development of clinics functioning under the schools.
3. Study homes for problem children.

CRIPPLED CHILDREN

The Subcommittee recommends an annual survey of crippled children by the school nurse, better and more facilities for muscle re-education and occupational therapy, and consistent follow-up after surgical operations on crippled children.

TUBERCULOSIS

We recommend a uniform diagnostic classification form for all personnel making tuberculosis surveys.

CANCER

Attention is directed to the article on page 360 of our September 1946 JOURNAL. In addition the Subcommittee urges:

1. Carefully regulated cancer education program in schools. The unemotional and scientific approach is necessary.
2. Emphasis on what medical profession is doing to meet social and economic phases of cancer—service students can render in disseminating cancer information—avoid clinical aspects of disease.
3. Units on health topics have, in the past, been prepared by the New Jersey Department of Education, in cooperation with official and non-official agencies. It is thought desirable to have two distinct units on cancer, one for biology courses and one for public health and safety courses, both being aimed at giving positive and constructive facts about cancer.
4. Information about cancer facilities in New Jersey should be assembled.
5. Science and physical education teachers develop this material to use in classroom and for general assembly topics.

VENEREAL DISEASE

Sex education in schools is recommended. The Subcommittee has approved the following motion:

That Dr. Tidwell, as Chairman, and the Chairmen of the other Advisory Committees concerned with the school health program act as a committee to study the program for improved school health in the public school system, to be worked out with other interested groups, particularly the Department of Education.

MATERNAL WELFARE

The Advisory Committee presented a revised "Obstetrical Procedures" and requested approval and distribution to hospitals and maternity homes in New Jersey. Also attention is called to the new "hospitals" being put into operation in New Jersey. Apparently anyone licensed to practice medicine and surgery can place beds in a building which meets requirements of sanitary code and call it a hospital. In contrast, maternity homes have to be licensed by the Bureau of Maternal and Child Health—a thorough inspection of equipment is made and need for home is passed on by County Medical Society.

The Public Health Committee approved a recommendation that this matter be investigated by the Medical Practice Committee in conjunction with the Department of Health and Department of Institutions and Agencies.

SAMUEL BLAUGRUND, M.D., Chairman.

COURSE IN Rx WRITING AND PHARMACEUTICAL LAW

Under the joint sponsorship of Rutgers University and the Essex County Pharmaceutical Association, a series of four lectures on pharmaceutical law, prescription writing and related subjects will be given at 8 p. m. on Wednesdays starting on October 30. The lectures will be at the College of Pharmacy (No. 1 Lincoln Ave., Newark) and will include a review of vehicles, incompatabilities, analgesics, legal responsibilities of physician and pharmacist, flavoring agents and the like. Further details may be obtained from Essex County Pharmaceutical Association at 52 Arlington St., Newark 2.

SUBCOMMITTEE ON PUBLIC RELATIONS

Report to Welfare Committee, September 15, 1946

The Committee reviewed the continuing public relations activities of the Society, found that the weekly newspaper releases were being issued regularly, and that about ten letters a month were being received from readers asking further information. The radio program was being carried on two stations, one in Newark and one in Trenton, both as sustaining programs without charge to the Society.

The question of better publicity for scientific meetings of the county societies was discussed. It was decided that the secretary of the Public Relations Committee would send to each county society reporter a guide to publicity pointing out how scientific material was best prepared for newspaper release with hints on the mechanism of effecting such publicity.

The effort of the committee to set up a speakers' bureau covering economic and administrative topics has so far been unsuccessful. The original plan had been to have three members from each Councilor District select a panel of speakers locally. The decision now is to ask each Judicial Councilor to propose suitable speakers from his area, so that there would eventually be a panel of speakers on economic topics, well distributed over the state, available to take the platform locally. The state office would maintain a file of appropriate material for briefing speakers who desired assistance.

Dr. Stanley Nichols, president of the State Health Congress, addressed the committee by invitation, outlining the present status of the Congress. The Trustees having already affirmed this Society's cooperation with the Congress, no further action was required at this time.

The Committee next turned its attention to the question of our employing professional, nonmedical, public relations counsel. Our public relations program has never approached the ambitious projects in effect in our neighboring states. An intensive and dynamic statewide public relations program, including inspired newspaper stories and editorials, photographic features, radio programs, and a continuing public-speaking project were some of the possibilities if a professional public relations counsel could be hired. One such agent had proposed a plan of that sort which would cost the Society about $8,000 a year. The Committee decided to postpone action on any such project until after the Trustees had decided whether we were to have an Executive Officer this year. If an Executive Officer were selected, much of the public relations program would naturally fall on his shoulders, and his advice on the matter of hiring professional counsel would necessarily be sought.

The secretary reported that requests frequently come to the state office asking for names of specialists or inquiring about the qualifications of indivdual physicians. General practice has been to ask such correspondents to go to their family physicians who would refer them to specialists. In exceptional instances, it was found advisable to send the inquirer a list of specialists in his area. The list used was the one obtained from the Medical Service Administration which in turn was made up of replies received when the MSA was solicting physicians for the veterans care project. This list was recognizably incomplete in that some specialists had failed to reply and were thus not listed. And in some cases, doctors of questionable specialized attainment had had themselves listed as specialists. The Committee felt that it was a proper function of the State Society to have adequate professional data on all physicians in the state and accordingly asks the Welfare Committee's approval of the following plan: that a questionnaire be sent to each doctor in the state asking him how he wants to be listed with reference to specialization and asking what hospitals he serves in that specialized capacity. Such questionnaires might also include compact information about specialized training. Similar blanks would be provided for county society secretaries so that new members would fill them out on application. In this way the Society would soon have a complete professional appraisal of the physicans of New Jersey. The Society would not, of course, determine qualifications or decide who was or was not a specialist. It would simply catalogue the physicans according to their actual hospital connections, announced specialties, and specialized training.

Announcement was made that the American Medical Association was planning an elaborate and nationwide radio program for 1947 in commemoration of the centennial year of the American Medical Association. The A. M. A. wanted each state society to nominate one physician in its history whose professional activities would lend themselves well to dramatization over the radio. The Committee voted to nominate Dr. Henry Coit as a fitting subject for such a program. It was felt that his original plan for certified milk did more to eliminate bovine tuberculosis in children than any thing in medical history, and that the subject

was peculiarly apt for radio dramatization. The Committee asks the Trustees' endorsement of this nomination.

The chairman of the committee then reported breifly on his visit to the National Physicians Committee meeting in St. Louis earlier this month. The report follows:

During the week of September 2, the National Physicians Committee held a special meeting in St. Louis. I was invited by Dr. Joseph Londrigan (Chairman of the New Jersey section of the N. P. C.) to accompany him to that meeting. We heard a complete report of the testimony before the Senate Committee on the Wagner-Murray-Dingell bill and had a chance to review the vast amount of work (much of it spark-pluged by the N. P. C.) necessary to meet the amazingly well organized forces which were seeking to enact this legislation. Fortunately the N. P. C. and other well-wishers of the American way managed to hold the line so effectively that the bill died in committee. As it will certainly be revived at the next session of the Congress, it is essential that we do not now relax our vigilance.

The National Physicians Committee has assembled a battery of well-written, hard hitting pamphlets, booklets and brochures on the general problems of distributing medical care and also on the specific programs advanced by Senator Wagner and Congressman Dingell. A study of this literature will repay the reading, both in the information it gives on basic problems in medical economics and in the lessons it teaches in medical public relations. I was particularly impressed by the emphasis laid on cultivating the individual doctor-to-patient relationship as a public relations technic for the entire profession. It was certainly the consensus at St. Louis that this could be one of the most useful public relations platforms available to us: our relationships as doctors to our own patients.

All physicians will receive some preliminary pamphlets from the N. P. C. in the near future. A coupon is attached to one of these and if you return the coupon, the N. P. C. will send you more material including a book on health insurance called "Compulsion, Key to Collectivism". This book affords a full-dress review of behind-the-scenes activities on behalf of compulsory insurance. Every alert practitioner will want to read the pamphlet and write for this book. It will give you a better briefing on the subject than anything heretofore available.

There was some discussion as to how far we could go in endorsing the activities of the N. P. C., since the A. M. A. was already on record as approving the objectives of that committee but not participating in their activities. The Trustees of The Medical Society of New Jersey decided in January, 1945, that the Society should endorse the "activities" of the National Physicians Committee and your Public Relations Committee takes this occasion to underline that policy and to urge its members on an individual basis to support the National Physicians Committee.

In summary, the Committee transacted routine business in connection with its continuing public relations program, recommends that any professionally-manned program be held up pending action on an Executive Officer and asks the cooperation of the general membership in setting up a bureau of speakers on economic topics.

We ask the Welfare Committee and Trustees to approve of our preparing a catalogue of the doctors of New Jersey with professional qualifications being listed therein, and ask approval of our nomination of Dr. Henry Coit as a suitable subject for the A. M. A. nationwide radio dramatizations next spring.

L. S. SICA, M.D., Chairman.

A. M. A. CENTENNIAL

JUNE 9-13, 1947
ATLANTIC CITY, N. J.

The coming A. M. A. meeting celebrates the 100th anniversary of the Association, promises to be one of the largest—if not the largest ever held.

The hotel facilities of Atlantic City will be taxed to capacity. It is therefore advisable that those who are planning to attend, write at an early date to the CONVENTION BUREAU, CENTRAL PIER, ATLANTIC CITY, N. J., requesting their reservation at a designated hotel. The applicant will receive his confirmation directly from the hotel. It is necessary, however, to have all applications for reservations clear through the Convention Bureau. Therefore, direct application to a hotel will be of no avail.

The Hotel Traymore has been reserved for the officers of the A. M. A. and the Delegates and therefore no rooms are available there.

NEWS ITEMS

The Salmon Lectures will be delivered this year by Dr. David M. Levy of New York. His subject is "Excursions in the New Fields of Psychiatry". The talks will be given on November 6, 13 and 20 at the New York Academy of Medicine Building.

• • •

An extensive program of graduate medical courses is now available in Newark. Most of the subjects are given in the late afternoon hours and are under the joint auspices of the Essex County Medical Society and Seton Hall College. For a complete catalogue of these courses, write to Essex County Medical Society, 91 Lincoln Park, Newark 5, attention: Post-Graduate Instruction Committee.

SUBCOMMITTEE ON MEDICAL PRACTICE
Report to Welfare Committee, September 15, 1946

The Advisory Committee on *Hospital Relationships* will carry out the recommendations made by its former chairman, Dr. Watson B. Morris, at the previous meeting. This includes a meeting with representatives of the N. J. Hospital Association to discuss the possibility of increasing medical representation on boards of trustees in the various hospitals.

On behalf of the Advisory Committee on *Pharmaceutical Problems* Dr. Ulmer called attention to the fact that two of the most valuable and active members of his committee, Dr. Ballinger and Dr. Remer, had died, and that this had been a marked loss to the activities of the committee.

The Advisory Committee on *Radiology* passed a resolution instructing Dr. Marquis to prepare a tentative plan outlining the relationship between a radiologist and his hospital, and to submit that plan to committee for approval.

Speaking for the Advisory Committee on *Workmen's Compensation,* Dr. Harryman reported that Mr. Harper of the Department of Labor had a bill prepared and introduced which would broaden the time limit for reporting injury in the hernia section of the Workmen's Compensation Law from 24 to 72 hours. The bill did not get out of committee because it was introduced too late, but it will be offered again in the fall. There is no reason why this bill should fail to pass as the Department of Labor, the insurance carriers and the labor unions are in favor of the revision.

The Subcommittee on Medical Practice recommends to the Welfare Committee that the insurance companies be approached with the recommendation that fees for compensation cases be placed on a par with fees charged the average private patient and with the fee schedule of the Veterans Administration.

The Subcommittee on Medical Practice recommends that Dr. Harryman be authorized to prepare an up-to-date revision of his paper on "Workmen's Compensation and the General Practitioner". This article appeared originally on page 453 of the September 1941 JOURNAL of The Medical Society of New Jersey and proved so valuable that the stock of reprints was soon exhausted. Requests for copies came from many states of the Union. The Subcommittee believes that the time is now ripe for a revision of that article and for its publication in our JOURNAL along with a schedule of disabilities.

The Advisory Committee on *Physical Medicine* is engaged in an analysis and discussion of the questions contained in its last report.

The Advisory Committee on *Laboratory Medicine* reported that the recommendations approved at its last meeting (see pages 288 and 289 of the July 1946 JOURNAL) have been referred to the Trustees for consideration.

WATSON B. MORRIS, M.D., Chairman.

COMMITTEE ON MILITARY SERVICE

Paralleling the Committee on Military Service of the A. M. A. each state medical society has been asked to name a similar body to "study the many communications that have been received and suggestions made by physicians in the armed forces. The committee will also formulate policies for recommendations to be forwarded through the Surgeons General to the Secretaries of War and Navy expressing the views of the medical profession in planning proper utilization of the services of physicians in any national emergency".

President Scammell announces the appointment of the following Committee on Military Service of The Medical Society of New Jersey under the chairmanship of Dr. Sharp:

Dr. Reuben L. Sharp, Camden
Dr. Stewart F. Alexander, Park Ridge
Dr. David B. Allman, Atlantic City
Dr. Stuart Z. Hawkes, Newark
Dr. William G. Herrman, Asbury Park
Dr. A. F. McBride, Jr., Paterson
Dr. Walter F. Phelan, Elizabeth

Members of The Medical Society of New Jersey are welcome to forward to the above committee any suggestions about proper utilization of medical personnel in the armed forces. Communications should be addressed to Dr. R. L. Sharp, Chairman, Committee on Military Service, The Medical Society of New Jersey, 315 West State Street, Trenton 8.

INCOME CEILINGS FOR MEDICAL SERVICE PLAN

Norman M. Scott, M.D., Newark, N. J.

The current relationship between the average income of employed persons and the cost of living has created a problem for voluntary medical service plans.

If these plans are to be successful in meeting the demands of the majority of people, if they are to be effective in forestalling the entry of the federal government in the field of compulsory prepaid medical service and if their enrollment is to be maintained on a sufficient percentage basis to assure their financial soundness, they must give a guaranty of complete payment for eligible services rendered persons in the under-average income group.

In any socio-economic developments which may take place in this country in the future, medicine will be a part, and this part will involve mainly the distribution of adequate medical care to "under average" income groups. In evolving a solution we must protect the dignity, pride and freedom of the "under average" income group if the ideals, freedom and soul of medicine are to be preserved.

This requires that each plan determine the level in its respective state below which incomes should be considered as "under-average".

When the program of society-sponsored plans started in 1940 and in 1942, the annual income levels allowed by the plans ranged from $2000 under single contracts to $3000 under family contracts.

Medical-Surgical Plan of New Jersey started operation in 1942. Our original contract provided that participating physicians would deem as payment in full the amounts payable by the Plan for eligible services rendered persons admitted to hospital for semiprivate or ward accommodations. This was done in the belief that private room accommodations would be available for, and be used by, persons with income above average in amount.

In 1944 this criterion was changed to one based upon specific income levels, the ceilings being $2000 annual income under the single person contract and $2500, plus $250 for each enrolled child, under the family contract. These income ceilings were determined with reference to living costs prevailing in 1943, the last full year prior to the change in our contract.

Assuming that the dollar had a purchasing power of 100 in 1941, when Medical-Surgical Plan contracts were framed, what should be our income levels if we are to meet the needs of the current "under-average income" group?

AVERAGE INCOME

The average weekly income of employed persons in New Jersey industry during this five-year period beginning with 1941 has been as follows: *1941,* $33.74; *1942,* $42.08; *1943,* $48.87; *1944,* $52.32; *1945,* $50.87. For *1946* the Department of Labor and the Department of Agriculture agree on the following levels of current average weekly industrial earnings in New Jersey: *January,* $46.66; *February,* $46.64; *March,* $47.20; *April,* $47.82; *May,* $48.08. There has been an increase of about 40 per cent in the average income since 1941.

THE COST OF LIVING

To assist us, the New Jersey Department of Agriculture has prepared the basic material in the following table depicting the economic changes altering the cost of living, using as a base the assumption that the dollar was worth 100 cents in 1941.

ADJUSTMENTS FOR CHANGES IN PURCHASING POWER OF DOLLAR

(Amounts required in 1942 and later years to furnish same purchasing power as amount shown in heading 1941.)

Year	Index* 1941=100	$2000 (Single employee)	$2500 (Employee and wife)	$3000 (Employee, wife & 2 children)
(1)	(2)	(3)	(4)	(5)
1941	100.00	$2000	$2500	$3000
1942	111.5	2230	2787	3344
1943	117.7	2353	2941	3529
1944	120.5	2410	3012	3614
1945	124.5	2491	3113	3736
1946	131.7	2635	3294	3953

* Includes all goods and services.

Source: Index numbers from "Consumers Prices in New Jersey" as compiled by New Jersey Department of Agriculture.

The point of this table is simply that if an employee and his wife enjoyed an income of $2500 in 1941 they would require an income of $2787 in 1942 and of $3294 in June, 1946, to maintain their purchasing power. Similarly for other arrangements set forth in the table.

If, to use the illustration referred to in the preceding paragraph, an employee and his wife have the same purchasing power with an income of $3294 in June, 1946, as with an income of $2500 in 1941, and if, under the Medical-Surgical Plan contract, they are entitled, in 1941, to full eligible medical services at scheduled rates, it may be that such full

services should be given in connection with incomes up to $3294 in June, 1946.

However, it is interesting to observe how these variable ceilings would have developed if Medical-Surgical Plan had enjoyed a longer experience, say since 1929. The index is not always upward. Taking the index in 1929 as 100, the indices for 1933 and 1940 and June, 1946, would be respectively, 75.4, 85.9, and 108.8. (For convenience the indices of the Bureau of Labor Statistics are used here.) Thus, a ceiling of $2500 appropriate in 1929 would be reduced to $1885 in 1933, would rise slightly to $2148 in 1941 and to $2720 in 1946.

Such variations in the relationship between average income and the cost of living lead to the thought that in fairness to our participating physicians and subscribers, the income limits applicable to our contract for any calendar year might be increased or decreased in the ratio of the New Jersey Consumers Price Index for the preceding or second preceding calendar year to such index for the year 1941.

The entire problem, including its implications, is being studied by the Board of Trustees of the Plan.

STATUS OF FEDERAL HEALTH LEGISLATION

During the life of the 79th Congress, almost 200 bills affecting health or of other interest to the profession, were introduced. One cannot help being impressed with the number of legislators who are anxious to have enacted measures having to do with some phase of public health. In this bulletin we shall merely report the disposition of the most important measures of public health interest. If there is any measure, not included in the following listing, on which you would like information please write to Dr. Frederic J. Quigley, 543 45th Street, Union City, N. J.

S. 191—Hill-Burton Hospital Construction Bill —Passed both houses and was signed by the President, now Public Law 725. The amendment providing that federal funds to the states be limited to 33⅓ per cent of the hospital construction cost was agreed to by the conference committee and this provision is in the present law.

S. 1606—After numerous hearings the latest version of the Wagner-Murray-Dingell Bill died in committee.

S. 2143—National Health Act, introduced by Senators Taft of Ohio, Smith of New Jersey and Ball of Minnesota, was not reported from committee.

S. 1318—The Pepper Maternal and Child Welfare Bill was abandoned in favor of S. J. Res. 177 which provided for increased appropriations for the Children's Bureau. This resolution died in committee. However, when H. R. 7037, Social Security Act Amendments of 1946, was before the Senate it was amended by adding provisions for increasing the appropriation of the Children's Bureau for maternal and child welfare, crippled children and dependent children activities. The appropriations requested were the same as those carried by S. J. Res. 177, totaling $19,725,000. In conference, however, the House Committee insisted upon a reduction of the total amount to $14,525,000. This was accepted by both houses and the bill has been signed by the President. While the appropriation is thus increased, there is no change in the law.

S. 962—School Lunch Programs—was abandoned for H. R. 3370, which was enacted into Public Law 197.

H. R. 4512, which is now Public Law 487, originally carried an appropriation for the construction and erection of a psychiatric institute and a sum to be allotted to the states. These two appropriations were stricken out of the bill by the House Conference Committee. The Public Health Service therefore may not be able to do much with this law until a new Congress allots it a suitable appropriation.

H. R. 2716, which has become Public Law 658, was finally amended so that the health services shall be provided on the recommendation of the Public Health Service alone. The original bill gave authority as well to the Civil Service Commission. These services "shall be established only in localities where there are sufficient numbers of Federal employees to warrant the provision of such services" and are "limited to (1) treatments on the job, illness and dental conditions requiring emergency attention; (2) pre-employment and other examinations; (3) referral of employees to private physicians and dentists; and (4) preventive programs relating to health". Osteopaths may be employed in this service.

H. R. 1362—Railroad Retirement Act, providing for cash sickness and maternity benefits, was passed and is now Public Law 573.

Frederic J. Quigley, M.D.,
Executive Secretary,
Subcommittee on Legislation.

RESIDENCIES AND INTERNSHIPS IN NEW JERSEY

Hospitals of New Jersey provide 146 residencies approved for specialty training and 400 accredited internships. Since inquiries are frequently sent to the Executive Office asking which hospitals are acceptable for specified residency or internship requirements, the following list is published for the information of all concerned. The information is furnished by the Council on Medical Education and Hospitals corrected to August 15, 1946.

INTERNSHIPS

Hospitals listed below provide the indicated number of internships acceptable to the American Medical Association. Arrangement is alphabetical by counties.

(8) *Atlantic:*
- 8—Atlantic City Hospital

(27) *Bergen:*
- 9—Englewood Hospital
- 10—Hackensack Hospital
- 8—Holy Name Hospital (Teaneck)

(4) *Burlington:*
- 4—Burlington Co. Hosp. (Mt. Holly)

(18) *Camden:*
- 10—Cooper Hospital (Camden)
- 8—West Jersey Homeopathic Hospital (Camden)

(90) *Essex:*
- 18—Beth Israel Hospital (Newark)
- 4—East Orange General Hospital
- 4—Lutheran Memorial Hospital (Newark)
- 12—Mountainside Hospital (Montclair)
- 24—Newark City Hospital
- 8—Orange Memorial Hospital
- 7—St. Barnabas Hospital (Newark)
- 3—St. James Hospital (Newark)
- 2—St. Mary's Hospital (Orange)
- 8—St. Michael's Hospital (Newark)

(134) *Hudson:*
- 6—Bayonne Hospital
- 14—Christ Hospital (Jersey City
- 89—Jersey City Hospital
- 7—North Hudson Hospital (Weehawken)
- 7—St. Francis Hospital (Jersey City)
- 11—St. Mary's Hospital (Hoboken)

(19) *Mercer:*
- 7—Mercer Hospital (Trenton)
- 8—St. Francis Hospital (Trenton)
- 4—William McKinley Hospital (Trenton)

(10) *Middlesex:*
- 5—Perth Amboy General Hospital
- 5—St. Peter's Hospital (New Brunswick)

(18) *Monmouth:*
- 9—Fitkin Memorial Hospital (Neptune)
- 9—Monmouth Memorial Hospital (Long Branch)

(8) *Morris:*
- 3—All Souls Hospital (Morristown)
- 5—Morristown Memorial Hospital

(33) *Passaic:*
- 5—Barnert Memorial (Paterson) Hospital
- 10—Paterson General Hospital
- 4—Passaic General Hospital
- 10—St. Joseph's Hospital (Paterson)
- 4—St. Mary's Hospital (Passaic)

(30) *Union:*
- 4—Alexian Brothers Hospital (Elizabeth)
- 10—Elizabeth General Hospital
- 8—Muhlenberg Hospital (Plainfield)
- 8—St. Elizabeth's Hospital (Elizabeth)

RESIDENCIES

Evaluation of residencies is now in a state of flux. Some hospitals have only a "temporary approval", while others (not listed here) are in the process of development and will soon be added to the index of approved residencies. The hospitals named below are considered, as of August 1946, to be in position to furnish acceptable residency training in accordance with the standards of the American Medical Association. Most of these listings have been made in collaboration with the appropriate specialty examining board. The 146 approved residencies in New Jersey are made up as follows:

- 22 in psychiatry
- 17 in tuberculosis
- 16 in obstetrics
- 15 in surgery
- 13 in orthopedics
- 9 in urology
- 8 in anesthesia
- 7 in communicable diseases
- 7 in internal medicine
- 6 in otology-laryngology
- 5 in ophthalmology
- 5 in pediatrics
- 5 in clinical pathology
- 4 in gynecology
- 2 in radiology
- 2 in malignant diseases
- 2 in plastic surgery
- 1 in chest surgery

No hospitals in this state have residencies approved either by the A. M. A. or by the boards for training in allergy, cardiology, dermatology, neurology, neurosurgery, gerontology or traumatic surgery. Hospitals approved by the Council on Medical Education and Hospitals (A. M. A.) for residencies are as follows (numeral indicates number of accredited residencies or assistant residencies):

Anesthesia:
- 2—West Jersey Homeopathic (Camden)
- 6—Jersey City Hospital

Chest Surgery: 1—Hudson County Tuberculosis Hospital

Communicable Diseases: 7—Essex County Isolation Hospital (Belleville)

Gynecology: 4—Jersey City Hospital

Internal Medicine: 7—Jersey City Hospital

Malignant Diseases: 2—Jersey City Hospital

Obstetrics:
2—Cooper Hospital (Camden)
14—Margaret Hague Maternity Hospital (Jersey City)

Ophthalmology:
3—Jersey City Hospital
2—Eye and Ear Infirmary (Newark)

Orthopedics:
1—Hospital and Home for Crippled Children (Newark)
6—Jersey City Hospital
2—Monmouth Memorial Hospital (Long Branch)
3—Orange Orthopedic Hospital
1—Trenton Orthopedic Hospital

Otolaryngology:
2—Eye and Ear Infirmary (Newark)
3—Jersey City Hospital
1—Newark City Hospital

Pathology:
1—Atlantic City Hospital
1—Jersey City Hospital
2—Newark Beth Israel Hospital
1—Paterson General Hospital

Pediatrics:
1—Babies Hospital (Newark)
3—Jersey City Hospital
1—St. Michael's Hospital (Newark)

Plastic Surgery:
2—St. Barnabas (Newark)

Psychiatry: New Jersey State Hospitals at Greystone Park (13), Marlboro (7) and Trenton (2)

Radiology:
1—Atlantic City Hospital
1—Newark Beth Israel Hospital

Surgery:
2—Atlantic City Hospital
1—Burlington County Hospital (Mt. Holly)
2—Cooper Hospital (Camden)
1—Hackensack Hospital
6—Jersey City Hospital
1—Mountainside Hospital (Montclair)
1—Newark Beth Israel Hospital
1—West Jersey Homeopathic Hospital (Camden)

Tuberculosis:
9—Essex Mountain Sanatorium (Verona)
5—Hudson County Tuberculosis Hospital (Jersey City)
3—New Jersey Sanatorium (Glen Gardner)

Urology:
1—Atlantic City Hospital
3—Bayonne Hospital
4—Jersey City Hospital
1—Newark City Hospital

EXAMINING BOARDS

Inquiries as to the status of newly developed residencies should be directed to the Council on Medical Education and Hospitals of the American Medical Association at 535 North Dearborn Street, Chicago 10. Physicians applying to the American Boards should write directly to the Board secretary for an opinion as to the acceptability of specified residencies. Sometimes Boards will accept a residency for only six months or one year's credit even though the term of service may be longer. The names and addresses of the Board secretaries follow:

Anesthesiology: Dr. Paul M. Wood, 745 Fifth Ave., New York 22, N. Y.

Dermatology: Dr. George M. Lewis, 66 East 66th St., New York, N. Y.

Gynecology: Dr. Paul Titus, 1015 Highland Building, Pittsburgh 6, Pa.

Internal Medicine: Dr. William A. Werrell, 1 West Main St., Madison 3, Wis.

Neurology: Dr. Francis J. Braceland, 102 Second Ave., SW, Rochester, Minn.

Neuro-surgery: Dr. Paul C. Bucy, 912 South Wood St., Chicago 12

Obstetrics: Dr. Paul Titus, 1015 Highland Building, Pittsburgh 6, Pa.

Ophthalmology: Dr. S. J. Beach, 56 Ivie Rd., Cape Cottage, Me.

Orthopedics: Dr. F. M. McKeever, 1136 West Sixth St., Los Angeles 14, Cal.

Otolaryngology: Dr. Dean M. Lierle, University Hospital, Iowa City, Ia.

Pathology: Dr. F. W. Hartman, Henry Ford Hospital, Detroit, Mich.

Pediatrics: Dr. Lee F. Hill, 3309 Forest Ave., Des Moines, Ia.

Plastic Surgery: Dr. James Barrett Brown, 400 Metropolitan Building, St. Louis 3, Mo.

Psychiatry: Dr. F. J. Braceland, 102 Second Ave., SW, Rochester, Minn.

Radiology: Dr. B. R. Kirklin, 102 Second Ave., SW, Rochester, Minn.

Surgery: Dr. J. Stewart Rodman, 225 South 15th St., Philadelphia, Pa.

Syphilology: Dr. George M. Lewis, 66 East 66th St., New York City

Urology: Dr. G. J. Thomas, 1409 Willow St., Minneapolis, Minn.

TRISTATE MEDICAL DIRECTORY

The new issue of the *Medical Directory of New York, New Jersey and Connecticut,* to be published early in 1947, may be ordered at a special pre-publication price of $6.00 by physicians who send a request, accompanied by a check, to the Executive Offices before November 10, 1946. Make check payable to The Medical Society of New Jersey and send it to the Society at 315 West State St., Trenton 8. If remittance is not received by November 10, the pre-publication copy (at this reduced price) cannot be reserved for you. The directory lists every physician and hospital in the three states, with name, address, phone, medical school, year of graduation, society membership and hospital connection for each doctor, and complete staff rosters for each hospital. This directory is the first new edition since 1941.

ASSOCIATES WANTED AND ASSOCIATES AVAILABLE

If interested in establishing contact with any of these physicians, write The Medical Society of New Jersey at 315 West State Street, Trenton 8, and indicate whether you are referring to notice 16, notice 17, etc.

ASSOCIATES AVAILABLE

16. MATURE GENERAL PRACTITIONER available as part-time associate for internist, dermatologist or obstetrician in northern New Jersey.

17. WELL TRAINED INTERNIST now completing residency, qualified for Boards, available next June for association with general practitioner or specialist in any part of state.

18. DERMATOLOGIST, BOARD DIPLOMATE; age 46; had 3 years as chief of dermatology in large Army hospital; now wants association with established dermatologist in any part of New Jersey.

19. WELL TRAINED INTERNIST available for association with a group.

20. GENERAL PRACTITIONER WITH COMBAT SURGERY EXPERIENCE AND ARMY SERVICE AS SECTION CHIEF IN INTERNAL MEDICINE available for association with established practitioner in Northern New Jersey. Age 38, graduate Grade A medical school, holds N. J. license.

24. ROENTGENOLOGIST, age 39, Board-eligible, formerly X-Ray Chief at army hospital, desires association with established radiologist or connection as roentgenologist to a group in northern New Jersey.

OFFICE SPACE AVAILABLE

21. SPACE AVAILABLE in medical office building in central Newark area, as co-tenant with established internist.

22. SPACE AVAILABLE in north Newark area.

ASSOCIATES NEEDED

23. OFFICE ASSOCIATE WANTED by busy practitioner in suburban Essex County.

A physician licensed in N. J. interested in (a) finding an office associate or (b) securing placement as an office associate may send a brief notice to that effect, listing essential details, to Executive Offices, Medical Society of N. J., at 315 West State Street, Trenton 8, N. J. There will be no charge for publication, but these notices will not be used to advertise practices, offices or equipment for purchase or sale. This free service is available to individual physicians only and not to companies or business organizations. October 20 is deadline for November notices.

SUPPLEMENTARY LIST OF MEMBERS No. 5

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

Bozzi, Robert, 406 Roseville av., Newark (7)
Burokus, Wm. J., 21 E. Pleasant av., Maywood (2)
Cameron, Albert, 300 N. State st., Dover, Del (18), temporary address
Christensen, Alexander, Lebanon (10)
Cook, Caroline Sanford, 27 E. Cliff st.,Somerville (18)
Deehl, Seymour R., 1026 E. Jersey st., Elizabeth (20)
Fadden, Francis J., Jr., 275 Engle st., Englewood (2)
Ferguson, John, Monmouth Memorial Hosp., Long Branch (13)
Fessler, William, 31 Knox av., Cliffside (2)
Ginsberg, Leon, Essex Co. Hosp., Cedar Grove (7)
Gordon, Sarah, 327 Cedar lane, Teaneck (2)
Hartmann, Edmund, 350 Main st., Somerville (18)
Hardy, Grace C., 60 Hillside av., Tenafly (2)
Hirsch, Samuel, 258 Lafayette av., Passaic (16)
Hoffman, Harry, Veterans Admin., Lyons (18)
Hopping, John S., River rd., Hanover (14)
Lowe, Louise, State st., Hackensack (2)
Luddecke, Hugh F., Morristown Memorial Hosp., Morristown (14)
Miller, M. H., 311 60th st., West New York (9)
Pauly, Arthur, 297 W. Summit st., Somerville (18)
Prall, Henry E., 755 Anderson av., Cliffside Park (2)
Pullen, Guy F., 111 Leonia av., Leonia (2)
Reitnauer, John S., Tenafly (2)
Roth, Daniel, 836 Garrison av., Teaneck (2)
Rubino, Nicholas, 67 N. Fourth st., Newark (7)
Spence, Harold G., 5414 Arlington av., Riverdale, N. Y. (7)
Weiner, Harry, 283 Franklin st., Bloomfield (7)

ASSOCIATE

Becker, Marvin C., 35 Leslie st., Newark (7)

NUTRITION IN EVERYDAY PRACTICE

S. WILLIAM KALB, M.D., Newark, N. J.
Chairman Nutrition Committee

1. *Is it true that alumina gel (amphogel) destroys the vitamins in the intestinal tract?*

   No. There appears to be no basis for the claims that absorbents will destroy vitamins or lead to nutritional deficiency.

2. *A patient, who was a prisoner of war, had ankle edema, weakness and paresthesia of the limbs with difficulty in walking. This was referred to as "electric" or "jumping" feet. He now has a recurrence of the "electric" feet with hyperesthesia of the soles of the feet. Is this associated with any nutritional deficiency?*

   These patients respond favorably to niacinamide 150 milligrammes twice daily in combination with the other members of the B complex.

3. *Can redness of the palms of the hands be treated with vitamin therapy?*

   No. Palmar erythema usually occurs in pregnant women and in patients with pulmonary or hepatic disease. In these cases, one may find protein deficiency as indicated by a low plasma albumin level. Amino acid therapy is indicated.

4. *What is the average protein intake for a normal individual?*

   One gramme of protein per kilogram of body weight in an adult. Two to four grammes per kilogram in children.

5. *Have you any suggestions on how the protein content of diets can be changed?*

   Yes. The protein content may be increased or decreased by adding or subtracting certain protein foods in the diet using the chart below.

Food	Amount	Protein Gms.	Fat Gms.	Carbohydrate Gms.
Egg	one	6.4	5.8	0.4
Milk	glass	8.2	9.4	11.8
Cheese, American	ounce	6.8	9.2	0.5
Pot cheese	½ cup	19.2	0.8	4.3
Milk, malted, plain	glass	29.2	17.0	141.2
Macaroni with cheese	serving	11.9	15.0	31.4
Spaghetti and meat sauce	serving	15.2	11.3	39.3
Fish (most)	serving	24.0	12.5	0.0
Clams	six	13.6	1.7	2.1
Meats, cooked	serving	30.0	6.0	0.0
Chicken, all classes	serving	21.0	4.7	0.0
Peanut butter	2 tblsp.	8.0	19.0	7.0
Chocolate bar	1	10.5	66.5	103.6
Beans, navy	½ cup	22.0	1.5	62.1
Beans, soy	½ cup	34.9	18.1	12.0
Egg nog	1 glass	14.6	15.2	22.2

OBITUARIES

DR. WELLS P. EAGLETON

For editorial comment on the death of Dr. Eagleton, see page 401 of this JOURNAL.

New Jersey lost its most distinguished physician with the death, on September 12, 1946, of Wells P. Eagleton. He died at his summer home in New Hampshire almost on the eve of his eighty-first birthday. Dr. Eagleton was born in Brooklyn on September 18, 1865. He received his M.D. degree from Columbia University at the age of 23, and after an internship at the Newark City Hospital decided to equip himself for the practice of otology and ophthalmology. Accordingly he obtained a residency at the Eye and Ear Infirmary in 1889—and eventually became medical director and chief of staff of that institution. He interested himself in civic and organizational affairs from the beginning of his practice. In 1908, at the age of 43, he became president of the Essex County Medical Society. Later he became a member of the State Commission for the Blind, chairman of the Newark Welfare Federation, and (during World War I) a major in the Medical Corps of the Army. In 1922 he published a pioneer book on brain abscess and two years later wrote his well-known volume on cavernous sinus thrombosis. Both these monographs have been translated into foreign languages. He was a contributor to the Jackson and Coates "System of the Nose, Throat and Ear Diseases" and a prolific writer on medical topics. An article by Dr. Eagleton appeared in volume 1 of this JOURNAL.

Dr. Eagleton was on the staff of almost every hospital in northern New Jersey. He was active in medical societies and served at one time or another as president of most of them. (See partial list in the editorial, page 401, this JOURNAL.) He was the first chairman of the Welfare Committee of The Medical Society of New Jersey. He was the Senior Fellow of this Society. For many years he was an active New Jersey delegate at A. M. A. conventions. The Newark *News* comments that "Dr. Eagleton's voice was frequently heard from the public platform and in the press supporting health legislation, opposing political interference in medical matters, taking sides in educational controversies and seeking to improve welfare conditions in his city and his state". The mansion at 93 Lincoln Park, Newark, which constitutes the annex to the Academy of Medicine of Northern New Jersey was a gift of Dr. and Mrs. Eagleton to the Academy.

DR. J. FRANKLIN REEVES

Dr. J. Franklin Reeves, chief surgeon at the Bridgeton Hospital, died at his home on September 18. Born in 1886, he received his medical education at the University of Pennsylvania and served as a medical officer in the first World War. Always active in medical society affairs, he served a term as president of the Cumberland County Medical Society. For many years he was a member of the Bridgeton Board of Education.

DR. DANIEL F. REMER

The Burlington County Medical Society lost one of its most active members on September 6, 1946, with the death of Dr. Daniel F. Remer. Dr. Remer had been practicing in Mount Holly since 1916. He was born in Lewisburg, Pa., in 1880, and was graduated from the University of Pennsylvania Medical School in 1910. He came at once to New Jersey and soon specialized in diseases of the eye, ear, nose and throat. He was chief of those departments at the Burlington County Hospital. Dr. Remer was active in civic affairs and was particularly interested in the maintenance of good relationships between the medical and pharmaceutical associations, having had long service on the Pharmaceutical Problems Committee of The Medical Society of New Jersey and the Joint Committee on Professional Relationships of the two organizations.

DR. PARRY M. SCOTT

Dr. Parry M. Scott, widely known Burlington County practitioner, died suddenly on July 11 at the age of 46. Born in Morgantown, West Virginia, Dr. Scott was graduated from the university of that state and received his medical training at the Jefferson Medical College where he was in the class of 1924. After serving an internship in Wheeling, West Virginia, he came to New Jersey in 1925 and established an office in Beverly. He was active in the Burlington County Medical Society and was staff surgeon at the hospitals in Mt. Holly and Riverside, N. J.

BOOK REVIEWS

Progress in Neurology and Psychiatry. Edited by E. A. Spiegel, M.D. Grune and Stratton, New York, 1946. Pp. 708. $8.00.

A full-dress, critical review of neuropsychiatry in 1945 is offered in this volume. The practitioner may find too much emphasis on the nonclinical aspects of the specialty—or as Spiegel prefers to call it, on the "basic theoretical foundation". The first 200 pages are devoted to anatomy, physiology, pharmacology and pathology. Clinical neurology is then crowded into 31 pages, compactly reviewed by Yaskin and Rupp. This is followed by special sections on epilepsy, neurosyphilis, neuro-roentgenology (fifteen pages of text without a single picture or plate!), nerve injuries, brain tumors, child psychiatry, war neuroses, projective tests, head injury, group therapy, psychoanalysis, psychosomatics, and shock therapy. Each chapter is assembled by a different editor, so that the style fluctuates considerably from section to section. In some chapters there is more padding than text, as for instance, in phrases like "considerably more has been written recently on this topic than on that, which perhaps is natural" or ". . . problems in the treatment of motor and sensory disorders have been frequently encountered in the past year" or "In presenting a review of the literature of child psychiatry for the year 1945 we have been limited by space and by time" . . . sentences which of course are utterly useless to the reader and tend only to make the book bulkier.

On the other hand, in most of the monographs (once they get started) all relevant material is brought together so that the reader does not have to hop from page to page in the back and forth shuttle that characterizes so many digest volumes; and the editors have never been afraid of attaching their own criticisms to the works which they abstract. The volume, as a whole, is focussed squarely on the needs of the neuropsychiatrist, for whom it should prove to be a solid reference work.

H. A. DAVIDSON, M.D.

Ophthalmology in the War Years. Vol. I. Edited by Meyer Wiener, M.D. Pp. 1166. Chicago, The Year Book Publishers, Inc. 1946. $13.50.

During the meeting of the American Academy of Ophthalmology and Oto-Laryngology in 1943, the Subcommittee on Ophthalmology of the National Research Council requested Dr. Wiener to organize, and act as chief of an editorial staff to review the literature of ophthalmology in the war years. It was felt that the men in the services would not have much of the literature available and that those at home would be so busy that they could not read many contributions even if they could be had. It was decided to review all obtainable articles published throughout the world, beginning with January, 1940, and continuing until there would again be a free exchange of literature.

The present volume includes the literature from January, 1940, through December, 1943. It represents an enormous amount of time and effort by a staff of 35 outstanding ophthalmologists. The second volume, now in preparation, will cover the literature from January, 1944, to June, 1946.

As a bibliography of world ophthalmic literature this work is as complete as possible. There are over 8,000 references. Many are reviewed or commented on by the editors. This undertaking fills a void that has existed since the discontinuance of the Year Book of Ophthalmology. It is to be hoped that a plan may be evolved to continue it in some form after the publication of the second volume.

ELBERT S. SHERMAN, M.D.

VETERANS CARE PLAN

PHYSICAL EXAMINATIONS FOR RATING PURPOSES

By EDWARD T. YORKE, M.D., Liaison Officer

Approximately 105,000 veterans are now awaiting physical examination for disability rating. Thirty thousand of these have claims pending and have not yet been rated. The others require re-examination because of a change in ratings. These figures apply to New Jersey.

More physicians than ever will be making physical examinations for rating purposes when the examination units under County Medical Society auspices get into full operation. In the absence of such units, unrated cases have accumulated and many requests for examination and treatment by private practitioners have been held up pending ratings.

Essential feature of the examinations is their use by a rating board in evaluating the degree of disability or loss of function associated with service-connected defects. A physician is a member of the rating board and the board is interested primarily in a claim made by the veteran with respect to specific defects. Hence every effort should be taken to reveal to the rating board (through the report of examination) the degree of disability and loss of function.

Veterans often present histories irrelevant to the claim filed against the government; for that reason, the specific examinations ordered by the rating board may be insufficient to study them. Special studies of defects not made in the veteran's original claim should not be recommended.

In making the examinations, physicians should be guided by the types of procedures ordered. Describe the findings from the disability point of view and establish a diagnosis based on the findings as obtained.

It has been stated that 30 to 40 per cent of the examinations received by the Veterans Administration are not suitable for rating purposes. Understanding the basic point of view regarding disability examinations, physicians can cut this to a negligible figure. Establishing local responsibility for adequacy of the examinations will also show an appreciable effect. Every effort should be made to prevent unfavorable impressions within the Veterans Administration regarding the quality of work done by physicians throughout New Jersey.

HEAVY CONCENTRATION OF VETERANS IN CERTAIN COUNTIES

Essex, Hudson and Bergen Counties together account for about 46 per cent of the veterans in New Jersey. Five more counties (Camden, Mercer, Middlesex, Passaic and Union) represent another 32 per cent. Thus eight counties account for 78 per cent of the veterans in this state. These figures point up the need for the fullest possible expansion of facilites within those counties for doing rating examinations on a fee basis. The number of veterans in each county is indicated in the next column. The proportion of World War II veterans living in each county is listed in the column headed "percentage". These figures are estimated as of September, 1946.

County	War 1	War 2	Percentage
Atlantic	4,600	14,765	3.0
Bergen	7,982	52,120	10.0
Burlington	3,100	11,793	2.1
Camden	7,100	32,971	6.1
Cape May	1,100	3,483	0.6
Cumberland	2,800	7,983	1.5
Essex	32,851	110,287	20.0
Gloucester	2,700	8,757	1.6
Hudson	32,245	88,986	16.0
Hunterdon	1,900	3,783	0.7
Mercer	6,900	27,721	5.1
Middlesex	4,842	31,249	6.0
Monmouth	4,052	19,258	3.5
Morris	3,200	15,146	3.0
Ocean	1,074	4,550	0.9
Passaic	10,500	38,896	7.2
Salem	2,600	5,385	1.0
Somerset	2,000	9,794	2.0
Sussex	900	3,398	0.6
Union	7,930	43,854	8.1
Warren	1,900	5,663	1.0
Totals	142,224	539,812	100.

VETERANS LIAISON COMMITTEE

Report to Welfare Committee, September 15, 1946

The members of the Veterans Liaison Committee are to be congratulated for the way in which they have tackled this problem. Appointed in the middle of August, they have, in a short time, done a splendid job.

Dr. Yorke, our Liaison Officer, has done yoeman work in approaching a solution to the one bugbear of all such plans. I refer of course to the red tape and paper work which seem to be inherent in projects of this sort. Dr. Yorke has arranged with the International Business Machines Corporation to render a service to this Society which will take care of practically all the paper work connected with the examination of veterans. It is to be understood that this report concerns the diagnostic or "rating" examinations, not the treatment program.

In Hudson County, for instance, there are six examining units. To each of these, authorizations will be sent by Dr. Yorke from his central office. If a hospital is to be used for, say, ten examinations on October first, then by September first, the unit will have received ten authorizations. These authorizations will have been made out by the I. B. M. machine. All the practitioner will need is a clerk to take the veterans' names. The physician examines the patient and signs the form. He will not have to write in claim numbers or dates of enlistment or data of that sort. The doctor then sends the form to Dr. Yorke who feeds it to an I. B. M. machine. It is then sent to the Veterans Administration, and the V. A. makes out checks to the individual doctors. With each check is a voucher showing what work has been done. A record is held by our central office.

Dr. Wood has already made contact with all the counties in his area and they are in the process of adopting this sort of plan.

The Central Committee met on September 15 with our attorney who is drawing documents to incorporate each county society, so that separate contracts may legally be made with the V. A. The plan in that respect will be similar to the contract arrangements made in and by Monmouth County.

I am asking each county to forward to the central office the names of the incorporators. There must be at least three names and there may be four or five. The incorporators should be physicians in good standing in the county society. Will those of you who are here speak to your county chairman or president and ask him to send in those names so that we can go ahead with the work? We want some of these units operating by November first at least.

The members of this committee are doing a magnificent job and I want to thank them for their energy and their help.

Joseph F. Londrigan, M.D., Chairman.

PAYMENT FOR MEDICAL CARE OF VETERANS

Norman M. Scott, M.D., Newark, N. J.

Frequent inquiries are received in the office of Medical Service Administration, to the tune of: "When are you going to pay me for medical care rendered under the Veterans Program?"

You *will* be paid for authorized services rendered the veteran under the Plan as operated by Medical Service Administration from March 15 to May 13, 1946. *When* you will be paid depends upon the time taken by Veterans Administration to honor our vouchers.

Total value of medical care rendered the veterans between March 15th and May 13th, based upon completed reports received from physicians, and at the agreed upon fee schedule, was $74,036.25.

The status of our vouchers for this service is as follows:

We have been paid the following:

Date of Voucher	Amount
March 28, 1946	$ 709.35
April 15, 1946	8,389.40
April 30, 1946	13,758.95
Total Paid	$22,857.70

The amount represented in these vouchers has been distributed to the physicians rendering the services.

There are outstanding the following vouchers which were submitted to Veterans Administration as of the date of the voucher but for which no payment has as yet been received by us:

Date of Voucher	Amount
May 15, 1946	$29,550.20
May 30, 1946	9,426.25
June 15, 1946	5,573.65
August 15, 1946	6,628.45
Total Outstanding	$51,178.55

We were informed that the May 15 voucher for $29,550.20 was forwarded to the Treasury Department office in New York City for payment on September 9. When our Treasury check is received we will distribute checks to the individual physicians who rendered the care covered by this voucher. This should be accomplished during the week of September 16. About 1300 checks must be prepared, 1300 envelopes addressed, and the necessary entries for each payment made on our accounting records.

There are about 700 authorized cases on which we have received no physician's reports. Early in August each of these doctors was notified that he must render his report within two weeks if he expected to receive payment for the authorized services. Later we extended this date to September 15. This allowed three months from May 13th (the last day we issued authorizations) for a physician to render his report. On September 16. we forwarded our last voucher to the Regional office of Veterans Administration. Reports received after that date will be returned to the physician.

COUNTY SOCIETY REPORTS

GLOUCESTER COUNTY

David R. Brewer, Jr., M.D., Reporter

At a meeting of the *Gloucester County Medical Society* held on June 16, 1946, the following were elected officers: *President,* DR. LOUIS COLLINS, Glassboro, an Army veteran who served in India; *Vice-President,* DR. JOSEPH F. HUGHES, Woodbury, an Army veteran who served in Newfoundland; *Secretary,* DR. CLARENCE BOWERSOX, Woodbury; *Treasurer,* DR. DON WEEMS, Wenonah; *Historian,* DR. DOROTHY ROGERS, Woodbury; *Reporter,* DR. DAVID R. BREWER, JR., Woodbury.

PASSAIC COUNTY

L. E. Thron, M.D., Reporter

The first meeting of the new year of the *Passaic County Medical Society* was held on September 17, 1946, in the Administration Building, Paterson, N. J., with the president, DR. HARRY WOLFSON, presiding.

Upon the favorable recommendation of the Board of Censors, the following new members were elected:

Active membership: Marion F. Kaletkowski, M.D.; Emmett D. Angell, M.D.

Associate membership: Charles M. Aronsohn, M.D.; Burton B. Pfeffer, M.D.; Mortimer H. Kassel, M.D.; Charles W. Ozier, M.D.; Joseph Shapiro, M.D.; James Edson, M.D.; Kurt Manrodt, Jr., M.D.

Membership dues for the coming year were fixed at $33.00 by resolution of the members of the Society. The treasurer reported that the State Society dues for 1947 have been raised to $25.00 per capita assessment. In addition there is an assessment of $1.00 per member for the County Society Physicians' Indigent Fund. Due to the increased number of members, it seems possible that the county society will be able to carry on with a $7.00 per capita assessment for the coming year which will enable us to continue with the same dues as in 1946.

A communication from Harrold A. Murray, M.D., chairman of the New Jersey Study of Child Health Services, was read by the secretary. Dr. Murray requested the cooperation of the physicians in the current Child Health Survey throughout the state.

The following resolution on the death of Dr. William Wallace MacAlister was read by Dr. Leslie R. Taber:

"Whereas, The members of the Passaic County medical Society learned with sorrow of the death of our esteemed member, Dr. William Wallace MacAlister.

"Be It Resolved, He will long be remembered for his unbounded loyalty and genuine interest in the welfare of the Passaic County Medical Society for a period of over forty years."

DR. EARL LEROY WOOD of Newark gave a resume of the present Veterans Medical Care Plan and introduced DR. EDWARD T. YORKE, who was delegated for duty with the Veterans Administration to inaugurate the new medical care plan.

The speaker of the evening was ALAN DEFOREST SMITH, M.D., professor of orthopedic surgery at Columbia University College of Physicians and Surgeons. Dr. Smith presented a complete discussion of the differential diagnosis of low back pain. He stressed the importance of a good history and physical examination and a neurologic examination of the lower extremities as well as pelvic examination.

WOMAN'S AUXILIARY

THE AUXILIARY AND THE PUBLIC

In the past a great deal has been said about "What the Woman's Auxiliary could do for The Medical Society of New Jersey" and "What the Auxiliary could do for the doctors of this State". This is important and I would not detract one thing from what has been said along these lines, but it seems to me that we have placed too much emphasis upon helping the doctor and not enough upon helping the patient. We should carry to the public the conviction that the Woman's Auxiliary is their friend and benefactor. To justify this conviction let us ask ourselves "What has the Woman's Auxiliary done?" "What is it doing and what should it continue to do for the people of New Jersey?" Our record of past accomplishments is one to be proud of. Yet, as long as there are sick to be treated, disease and accidents to be prevented, and wrongs to be righted, our work will not be done. As long as there is one person in New Jersey who is not receiving adequate medical care, the doctors' wives can not cease their efforts to improve matters.

What can we do? Obviously we must work with and through the practicing physicians of the State. Doctors are busy individuals with but little time to listen to a flood of details. The doctor's wife often becomes an ambassador between doctor and patient. As such, she is the means of bringing about a better understanding of many problems which have a bearing upon the patient's health. Each of us is an ambassador between her husband and many of his difficult patients. This individual service has very little to do with us as an organized auxiliary, yet it shows the "stuff" from which the Auxiliary is made. The Auxiliary is made up of unselfish, self-sacrificing women, who, together with their husbands serve the sick and distressed people of our state.

What can we do collectively as an organized body for the people of New Jersey who are our neighbors? Through our public relations activities we can bring about a better understanding between the public and organized medicine which is striving sincerely to bring the best possible service to all who are in need of medical care. We can oppose movements which would destroy the freedom of patient and doctor. The patient's best interests are supreme and the benefit to the doctor is but secondary. We must contradict those enemies of organized medicine who would have the public believe that doctors are selfish individuals who are interested only in their own welfare.

Public health too is our concern. Committees in this field have done much. Their activities should be continued and expanded.

Hygeia should find its way into more and more homes. No doctor's waiting room should be without a copy. Public libraries and school libraries should have it upon their tables of periodicals. Thus, sound health advice would reach the eyes and attention of more and more individuals.

Activities in the field of accident prevention should be expanded and carried into every county. Cooperation with existing safety organizations rather than independent effort will in most instances bring the best results.

In these days when the nation is cancer conscious the Woman's Auxiliary should assume its full share of the responsibility in helping fight this disease. Again cooperation rather than independent action should be encouraged.

Whenever and wherever a question affecting public health within the state of New Jersey arises, the Woman's Auxiliary should be actively interested, and should take such steps as are practical in bringing about a just and sane solution.

Doctors who have been away serving their country in war are returning to civilian practice. Each County Auxiliary should take particular pains to see to it that the wife of the doctor veteran is invited to Auxiliary meetings. She should be made to feel that she and her husband are welcome in the community, and if she is eligible, she should be invited to join the Auxiliary.

Continuation of our efforts, stimulated by a realization that "nothing is good enough that can be improved" should carry us to higher and higher spheres of usefulness. The details of these general ideas are being worked out by our able President and her various committees. We should give her our wholehearted support.

REGIONAL CONFERENCE

Mrs. Frederick G. Wandall, President, opened the regional conference of the Woman's Auxiliary to The Medical Society of New Jersey at 11 a. m. Thursday, September 5, 1946, in the Executive Offices of The Medical Society in Trenton. She spoke of the purposes and functions of the Auxiliary, and urged closer cooperation among Auxiliary members Dr. William E. Dodd of Beach Haven, adviser to the Auxiliary, was introduced by the program chairman, Mrs. C. Chester Chianese. The Medical Society, according to Dr. Dodd, feels that the Auxiliary can be of help in presenting the viewpoint of organized medicine to the public.

The Program Books, Handbooks from the Woman's Auxilary to The American Medical Association, and literature on the Medical-Surgical Plan of New Jersey were distributed, and the announcement made of the availability of this literature to all. Reports of all chairmen followed, and advise and instructions for the year were given. The conference adjourned promptly at 1 p. m.

AUXILIARY REPORTS

Atlantic County

Mrs. S. L. Salasin

Mrs. Charles Hyman, President of the *Woman's Auxiliary to the Atlantic County Medical Society,* entertained the Executive Board at luncheon at the Traymore Hotel August 7. At a business session following the luncheon it was decided that all meetings this year will be held the second Friday of each month at the Traymore Hotel.

Mrs. Frederick G. Wandall, President of the Auxiliary to The Medical Society of New Jersey, will be the guest speaker in October.

At the November meeting there will be a book review.

The Christmas party will be the special feature in December.

In January a social hour will follow the business.

There will be a musicale in February.

The Public Relations meeting is scheduled for March. The guest speakers will include Dr. David B. Allman, who will discuss "Infantile Paralysis"; and Dr. William Kalb, whose subject will be "Nutrition".

Motion pictures will be shown at the April meeting.

The annual election and installation of officers will take place in May.

Several communications were read. Among them were letters from The Atlantic City Teacher's Forum; Dr. Harrold Murray of the Academy of Pediatrics; and Mrs. David B. Allman, thanking the Auxiliary for honoring her as the First Vice President of the National Auxiliary, at a tea.

Mrs. Hyman reported the collection of $159 in a recent Cancer Control drive.

Gloucester County

Mrs. J. F. Hughes

The officers of the *Woman's Auxiliary to the Gloucester County Medical Society* met at the home of the program chairman, Mrs. William Frederick, in Glassboro on June 25. Plans for 1946 and 1947 were worked out. The next project will be a business meeting on September 19 to be followed by an educational tour of the Owens-Illinois Glass Company plant in Glassboro.

SHARE WITH THEM

Now is the time to give to the USO. For those still in service, still in hospitals, or now in training.

NOW is the time to give to your Community Chest. Your Red Feather health, welfare and recreation services need your help.

In most large cities in the country, their campaigns are united.

Support the USO and your Community Chest.

Tuberculosis Abstracts

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XIX **October, 1946** **No. 10**

TRAVEL by air has become so commonplace that it is easy to overlook the fact that the altitude to which commercial planes ascend constitutes a risk to individuals whose pulmonary tuberculosis is under treatment by means of pneumothorax. The recent report* of the death, during flight, of a patient under treatment by pneumothorax, sharply emphasizes this hazard.

EFFECT OF ALTITUDE ON CASES OF PNEUMOTHORAX

One of the most useful forms of treatment for cases of pulmonary tuberculosis is artificial pneumothorax. Since a great number of people having an artificial pneumothorax wish to fly by air in the course of business it is very important that a correct understanding of what happens in the pneumothorax, at varying altitudes, be thoroughly appreciated.

Boyle's law states that, if the temperature remains constant, the volume occupied by a given quantity of gas varies inversely as the absolute pressure exerted upon it or, conversely, if the gas cannot expand, the differences of pressure correspondingly increase. The law covers the behaviour of gas in a thoracic cavity as in pneumothorax, during ascent and descent in an airplane.

During the war, experiments were carried out in a specially constructed chamber in which it was possible to reproduce exactly the same air pressure as at varying altitudes. An X-ray and fluoroscope were fitted in the chamber and the effect of ascent from ground level to any height desired was watched in each case. The patient was first X-rayed at ground level, then X-rayed and screened every 1,000 feet until he had reached a height beyond which it would not be advisable to proceed lest the pneumothorax were pushed beyond a safe collapse.

Various factors alter the height to which it is safe to go. In a case without adhesions and with a fixed mediastinum, with the collapse necessary to prevent the disease being active, greater heights will be possible if the lung is allowed almost to re-expand before the flight. The value of going to these heights, however, will be outweighed by the damage done to the intra-pulmonary lesion by allowing too much re-expansion of the lung.

A gradual collapse of the lung will occur as the altitude increases which the patient will notice at about 6,000 feet. At 8,000 feet, he will probably feel very tight in the chest and will be breathless on slight exertion. The limit beyond which it is not safe to proceed is generally 9,000 feet in these cases. Those with a mobile mediastinum can proceed to about 11,000 feet if the opposite lung is allowed to become compressed, but this is not to be recommended.

Cases with adhesions should never go above 6,000 feet. Two cases with apical adhesions were able to proceed to 9,000 feet although they complained of feeling very dyspnoeic and tight in the chest. Both, at a later date, developed fluid which necessitated a thoracoplasty being performed. The same facts held good in pneumothoraces in which part of a lobe, or a whole lobe, was adherent to the chest wall. When these cases are at an altitude of about 8,000 feet the pulse rate is considerably increased and the vital capacity greatly reduced. In addition, there is dyspnoea and tight feeling in the chest. The drop in vital capacity is more in cases of mobile mediastinum than in fixed mediastinum, or cases with adhesions. In the experiments mentioned, where there was a mobile mediastinum the vital capacity at ground level was 2,550, and fell to 1,600 at 8,000 feet where one with fixed mediastinum only fell from 3,000 to 2,500.

The length of time it is possible to remain at the highest altitude to which it is safe to go is important. If it is necessary to fly at this higher altitude for any time over ten minutes, then at

* Dowd, K. E., Aviation Medicine, October, 1945.

other times during the flight 6,000 feet should not be exceeded.

Cases of pulmonary tuberculosis who have had other forms of treatment, such as phrenic crush or thoracoplasty, can, of course, fly to much greater altitudes without ill effects. One case of thoracoplasty, in an R.A.F. pilot, was taken to 30,000 feet without ill effects. Those who have had no treatment other than sanatorium routine, can fly to the same height as a normal individual without harm to their pulmonary lesions.

Pleural effusion cases clearly should not fly during the active phase when fluid is present, but once the case has been arrested and the fluid absorbed, they can fly just as any normal person.

No harm should befall cases of pneumothorax if they do not fly above 6,000 feet as a rule, nor above 9,000 feet in a shorter emergency not exceeding ten minutes.

In days to come, when pressure cabins are a general rule in airplanes, pneumothorax cases should be able to fly at any altitude to all parts of the world.

Effect of Altitude on Cases of Pneumothorax, Geoffrey S. Todd, NAPT Bulletin, April, 1946.

EFFECT OF ALTITUDE ON ABNORMAL ACCUMULATIONS OF AIR IN THE CHEST

A patient with uncomplicated pneumothorax carrying 1,000 cc of intrapleural air at sea level will have the equivalent of 1,270 cc at 6,000 feet, 1,490 cc at 10,000 feet and 2,120 cc at 18,000 feet. We believe air travel for patients with pneumothorax should be restricted to those who would have no respiratory or circulatory distress and no physical discomfort if the abnormally accumulated air in the chest were increased by 100 per cent. An increase of 50 per cent would be permissible if the patient did not have to fly above 10,000 feet. Adequate amounts of air should be removed prior to flight if dangerous increase in pulmonary collapse is expected at higher altitudes. The patient should breathe pure oxygen by mask if there is any possibility of hypoxia.

Effect of Altitude on Abnormal Accumulations of Air in the Chest, Ezra Bridge and Ezra Bridge, The American Review of Tuberculosis, June, 1945.

DANGERS OF AERIAL TRANSPORTATION TO PERSONS WITH PNEUMOTHORAX

Evidence accumulated seems adequate to justify warning all patients with pneumothorax to avoid transportation by airplane unless they can be assured that no altitude will be attained beyond that which they have previously tolerated without discomfort. Even under the latter condition it is possible that some harm might be done to unstable tuberculous lesions by the rather large degrees of alternate expansion and collapse which may be occurring repeatedly during a flight, especially when there are frequent landings.

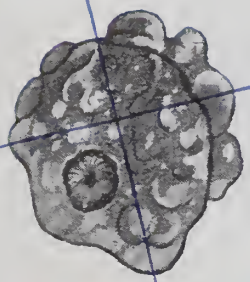
Dangers of Aerial Transportation to Persons with Pneumothorax, W. Randolph Lovelace II, M.D., and H. Corwin Hinshaw, M.D., Journal of the American Medical Association, April 11, 1942.

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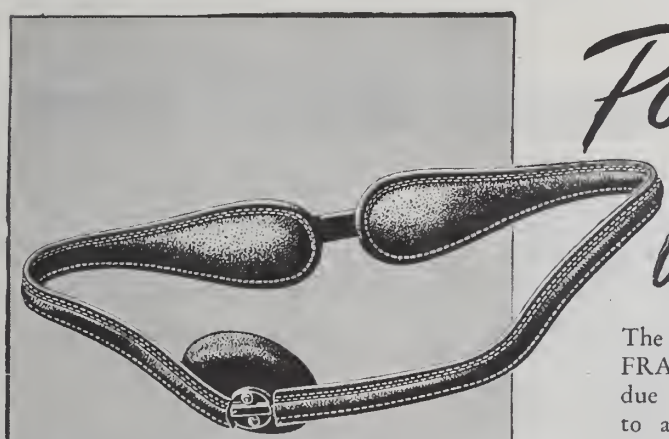


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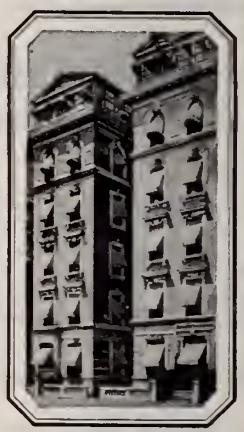


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*Frazer, J. G.: The Golden Bough, vol. 1, New York, Macmillan & Co., 1923.



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Entered as second-class matter, September 5, 1906, at the post office at Orange, New Jersey, under Act of March 3, 1879.

VOL. 43, NO. 11 NOVEMBER, 1946 Subscriptions, $3.00 per Year
Single Copies, 30 Cents

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Place of Publication, Printing and Mailing:
12 South Day St., Orange, N. J.

Editorial and Executive Offices of the Society:
315 West State St., Trenton 8, N. J.

Send all communications to the Trenton Office, telephone Trenton 5776

Acceptance for mailing at special rate of postage provided for in Sec. 1103, Act of Oct. 3, 1917, authorized July 29, 1918.

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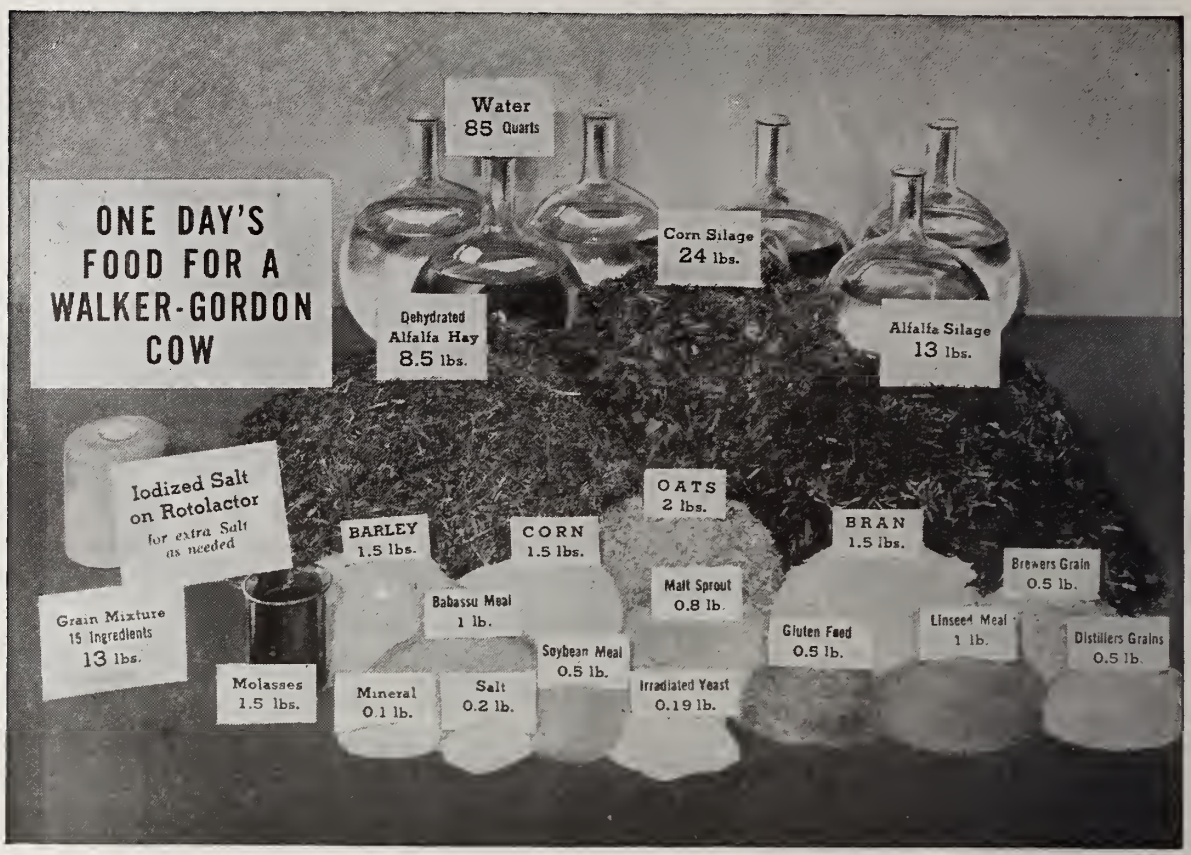
1. Dannenberg, M.: Am. J. Roentgenol. 51:328, 1944.

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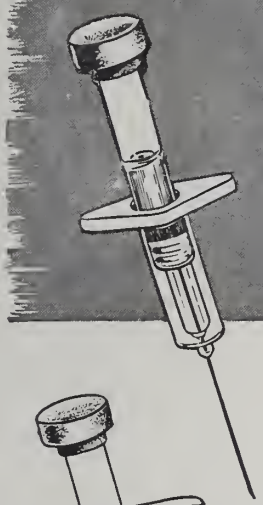
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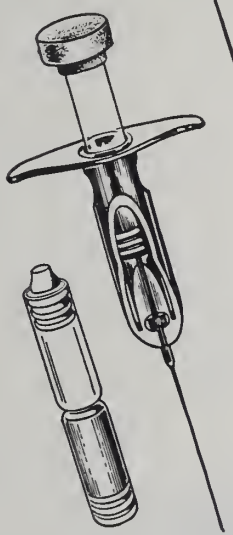
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CIBA



1 Congested Mucosa. Schemotic illustrotion showing the congested and moderotely inflomed nosol mucous membrane.

2 Destruction of Cilia. Highly alkaline preporotions, powerful astringents ond protein precipitonts may interfere with ciliary octivity.

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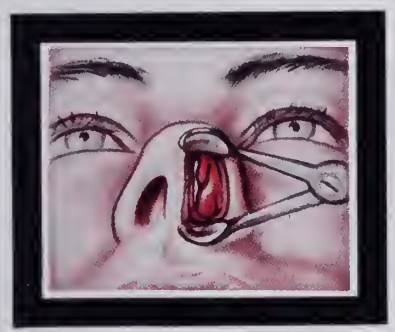
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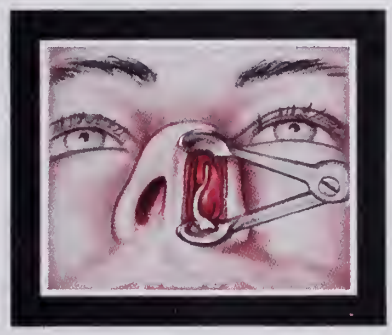
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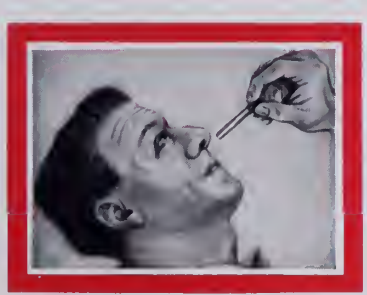
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Ethmoidal Sinusitis



Maxillary Sinusitis



Drop Instillation



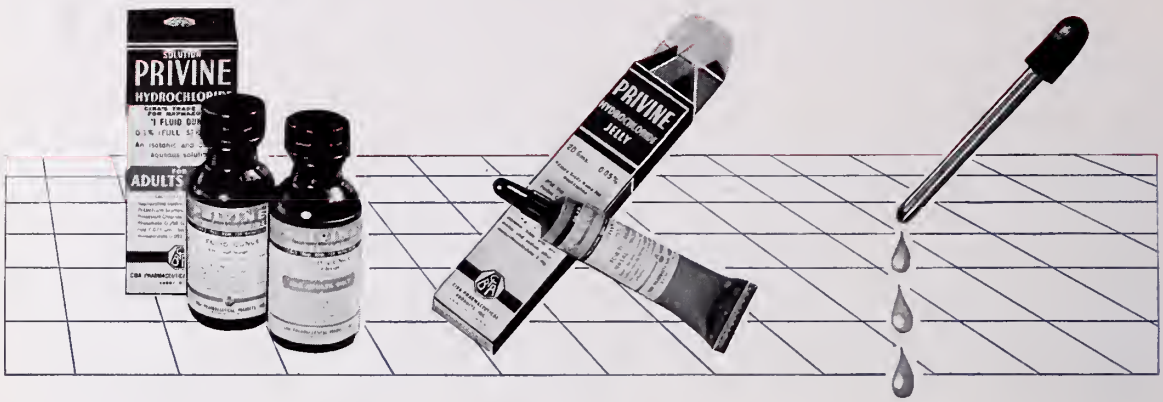
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BIBLIOGRAPHY:
1. Tweedie, A. R.: Jl. Laryng. & Otal., 49: 586, 1934.
2. Fabricant, N. D.: Arch. Otal., 33: 150, 1941.
3. Fabricant, N. D.: Arch. Otal., 41: 53, 1945.
4. Scheer, H. M.: New York State Jl. Med., July 1, 1946.



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1. *Montgomery, J. B.: M. Clin. North America 29:205 (Nov.) 1945.*

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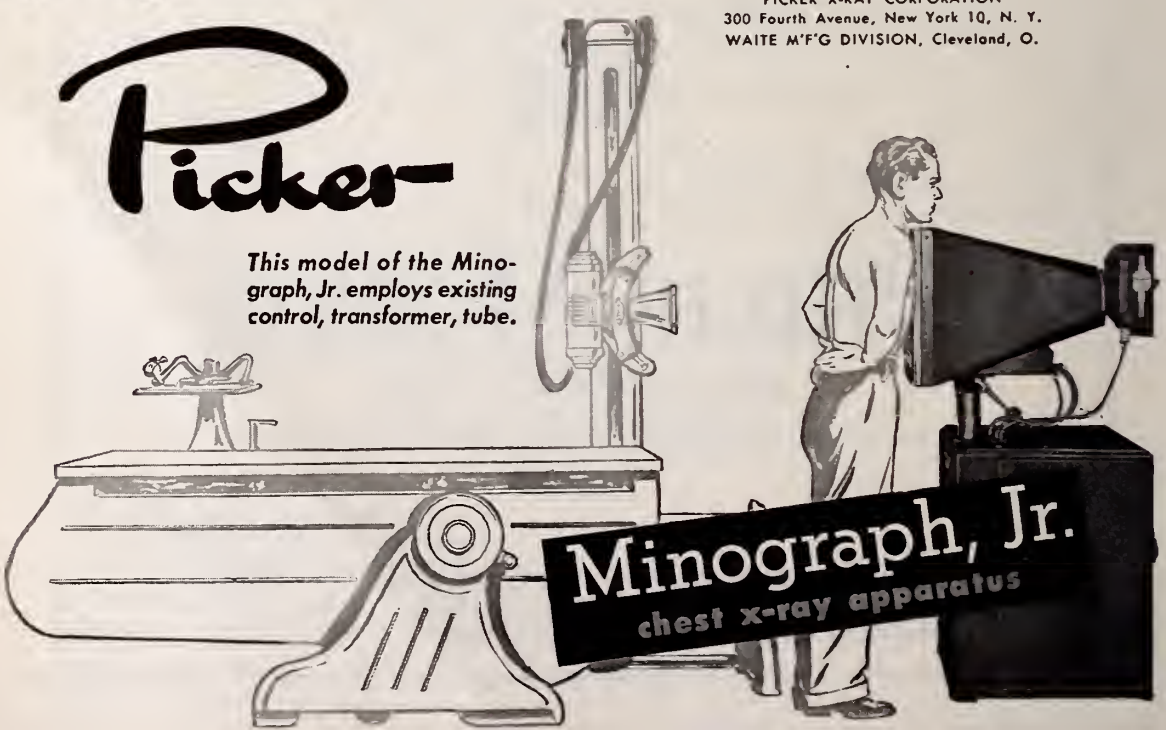
The new *Minograph, Jr.* fluororadiographic units bring to small-group chest work the efficiency and economies which have made the Picker automatic 70 mm. *Minograph, Sr.* supreme in the large-group survey field. These low-cost units employ specially designed Picker single-frame cameras, 35 mm. or 70 mm., or 4" x 5". There are *Minograph, Jr.* combinations with complete generating and control systems: still other models are operable, as auxiliaries, with existing equipment.

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This model of the Minograph, Jr. employs existing control, transformer, tube.



Minograph, Jr.

chest x-ray apparatus



the wounds after surgery . . .

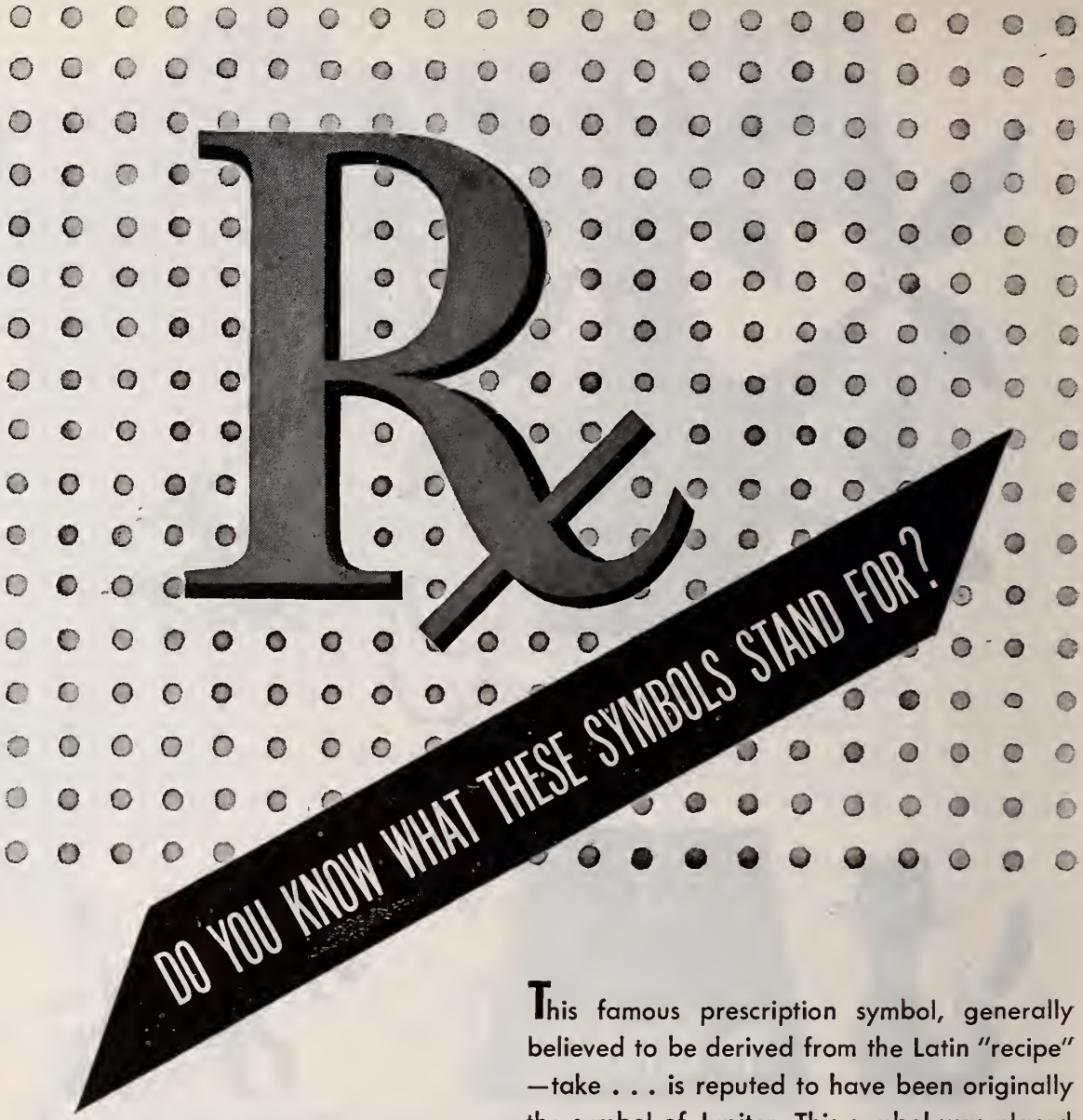
Modern surgical care recognizes that it takes more than gauze and adhesive to "bind the wounds" of the operative case. It has been demonstrated that the prevention and treatment of nutritional deficiencies may be "decisive factors" in recovery following surgery.[1] In the field of oral and parenteral vitamins, Upjohn offers a full range of highly potent, convenient to administer, economical vitamins.

1. Am. J. Surg. 44:288 (April) 1942.

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No, a biopsy is not indicated, but medical examinations and histologic studies on rickets prophylaxis have uncovered some enlightening figures . . .

Bone Biopsies on these huskies?



. . . on the *prevalence* of rickets: 90% of 943 apparently "normal" pre-school children presented signs of rickets.[1]

. . . on the *age* affected by rickets: 46.5% of 230 children aged 2 to 14 revealed histologic evidence of rickets, with a high of 62% in the *10 to 11* year group.[2]

. . . on the need for better *protection:* "Older children require prophylactic doses of vitamin D until maturity, especially during the periods of rapid growth."[3]

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1. Moore, C. U., Brodie, J. L., Thornton, A. J., Lesem, A. M., Cordua, O. B.: Failure of Abundant Sunshine to Protect Against Rickets, Am. J. Dis. Child., *54*: 1227-28, (Dec.) 1937.

2. Follis, R. H. Jr., Jackson, D., Elliot, M. M., Park, E. A.: Prevalence of Rickets in Children Between Two and Fourteen Years of Age, Am. J. Dis. Child., 66:1-11 (July) 1943.

3. Kugelmass, I. N.: Newer Nutrition in Pediatric Practice, p. 656, Lippincott, Philadelphia, 1940.

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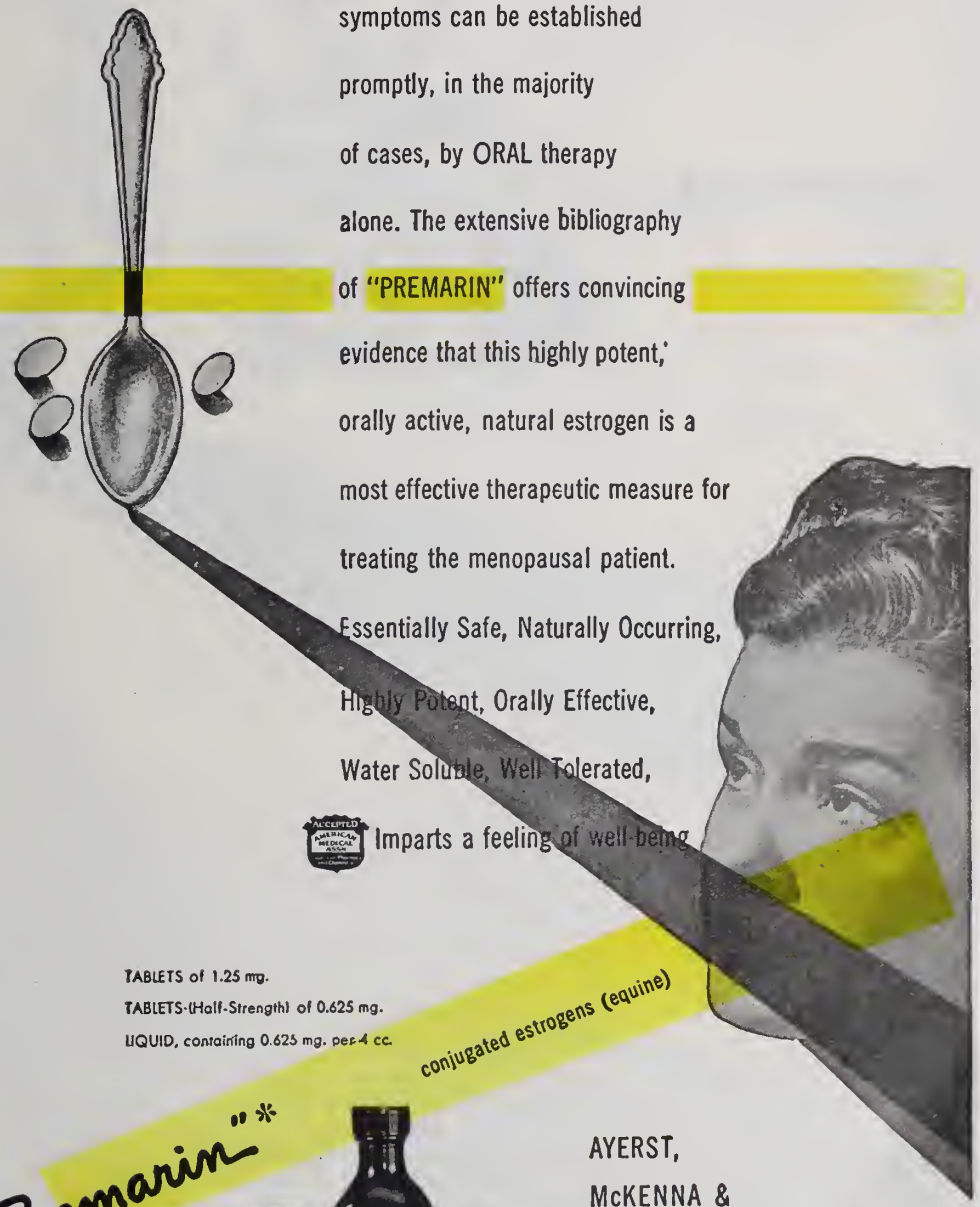
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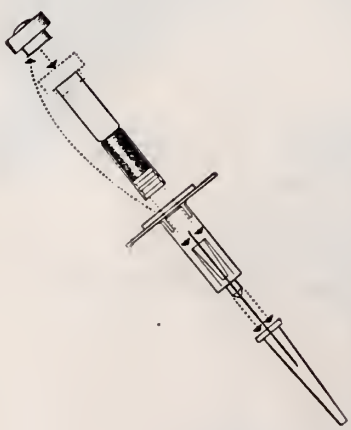


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*J.A.M.A. May 4, 1946

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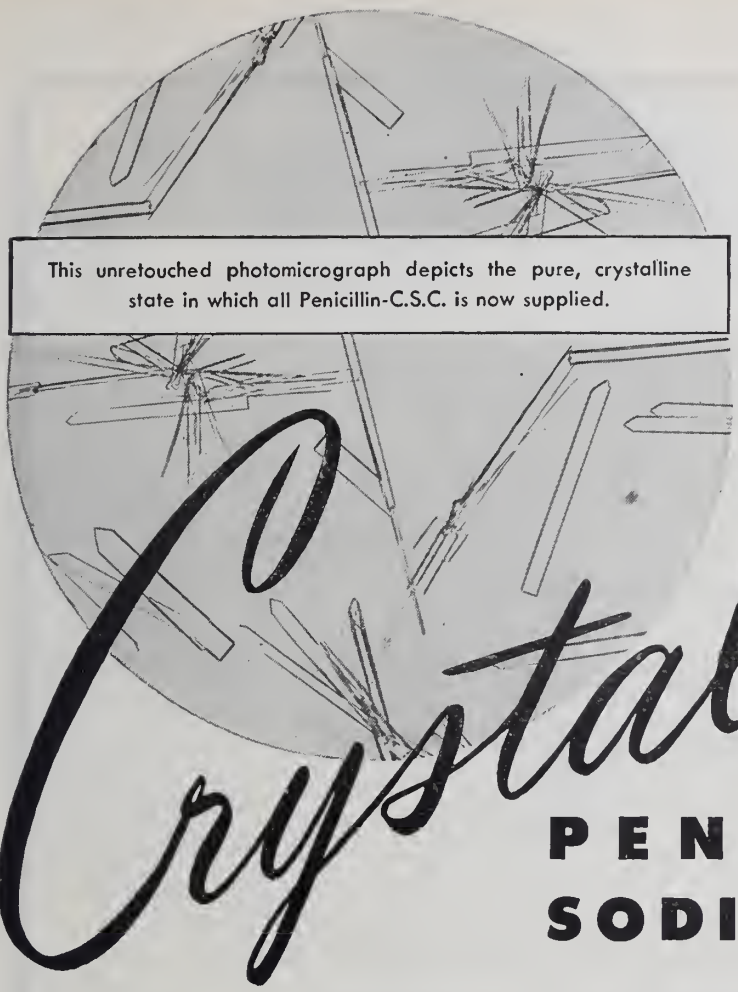
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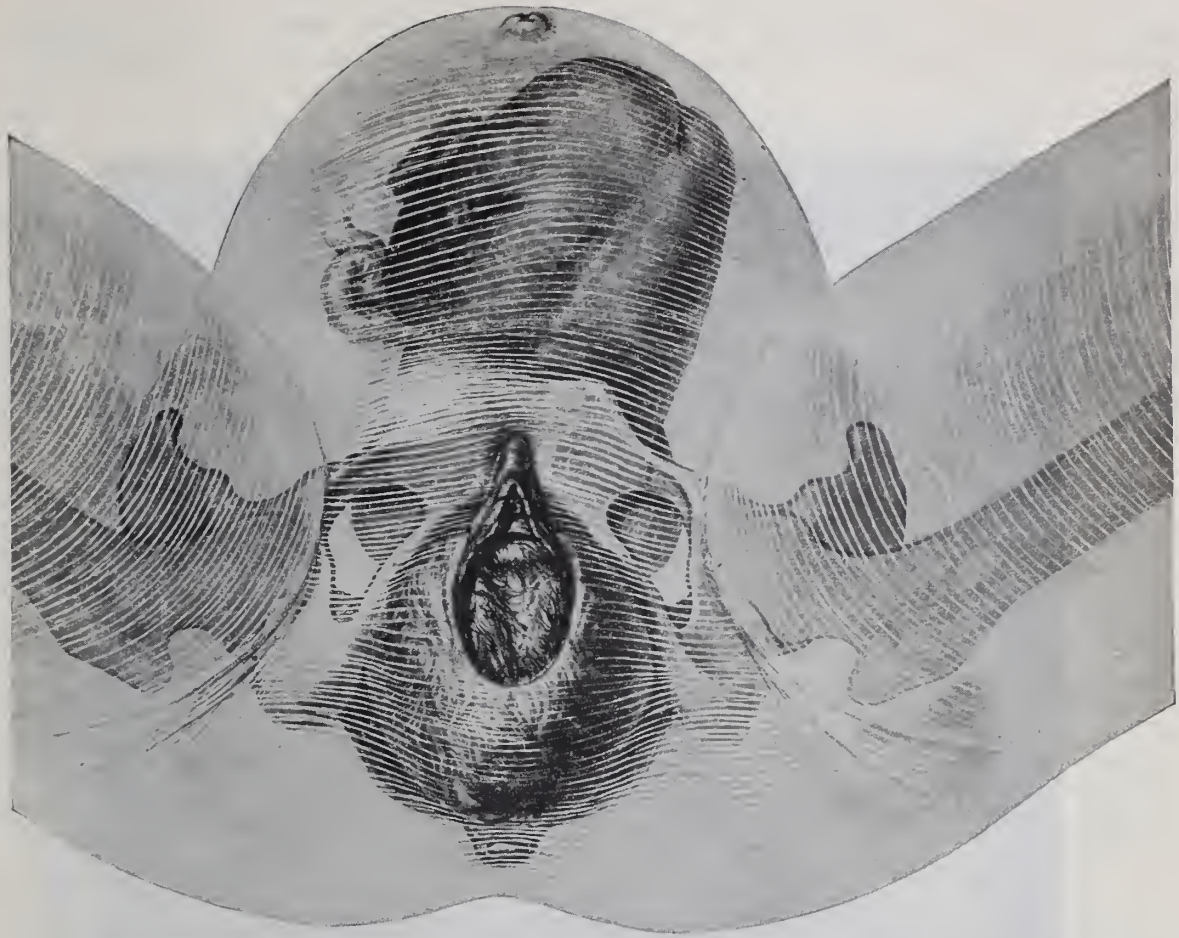
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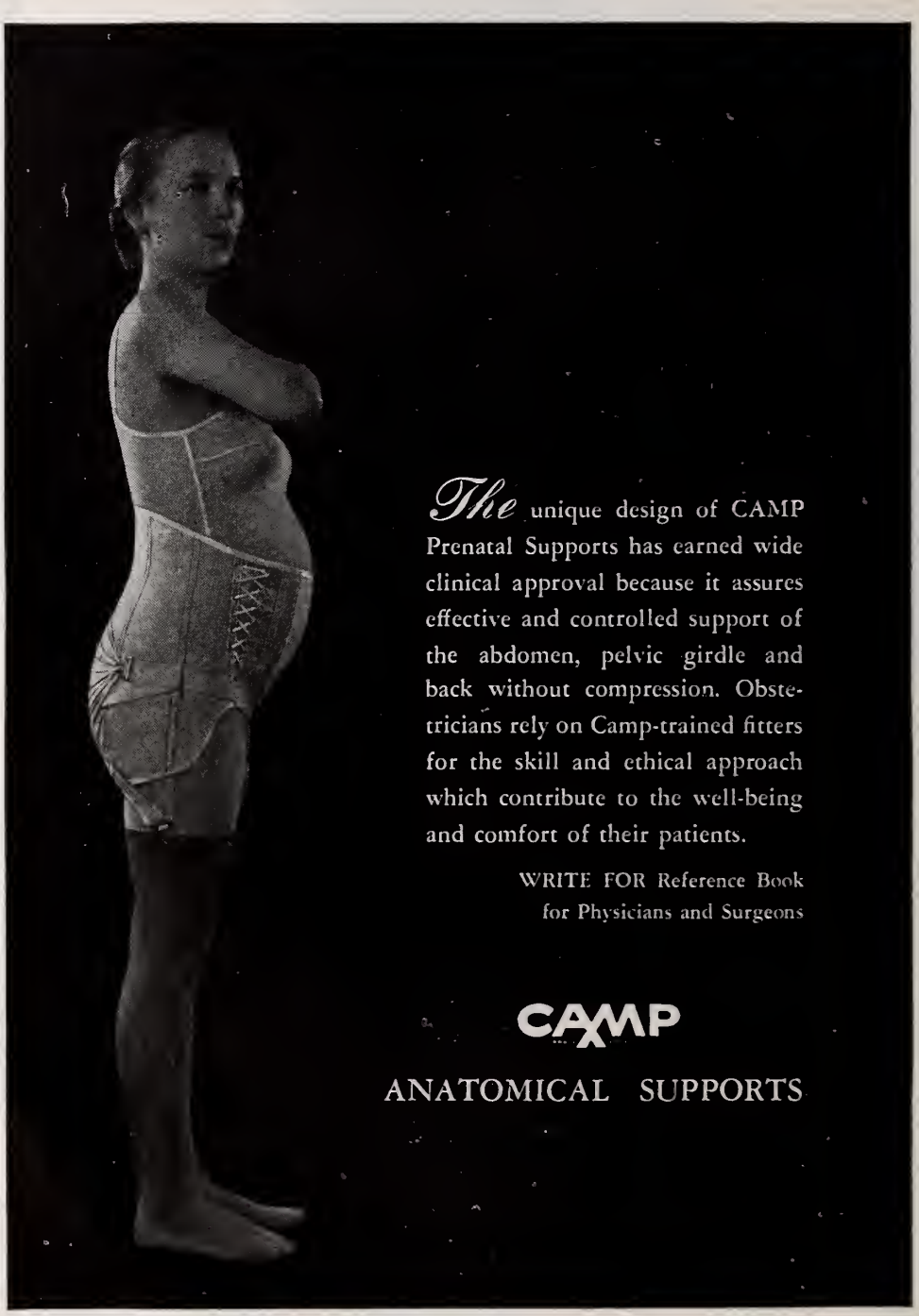
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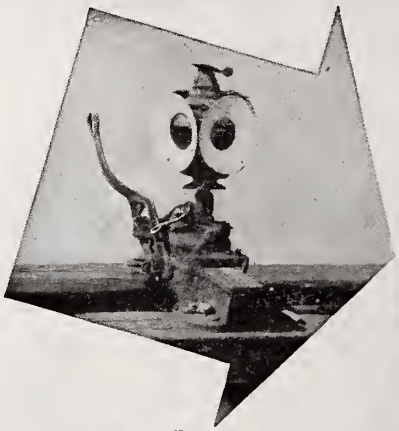
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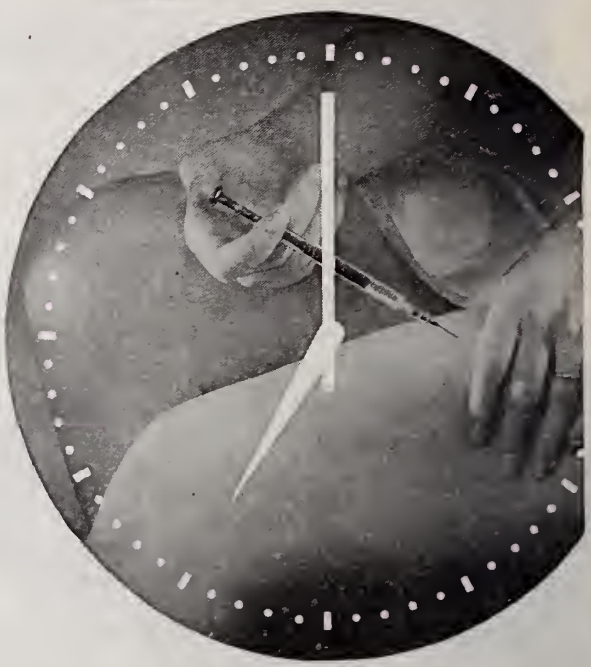
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treatment with

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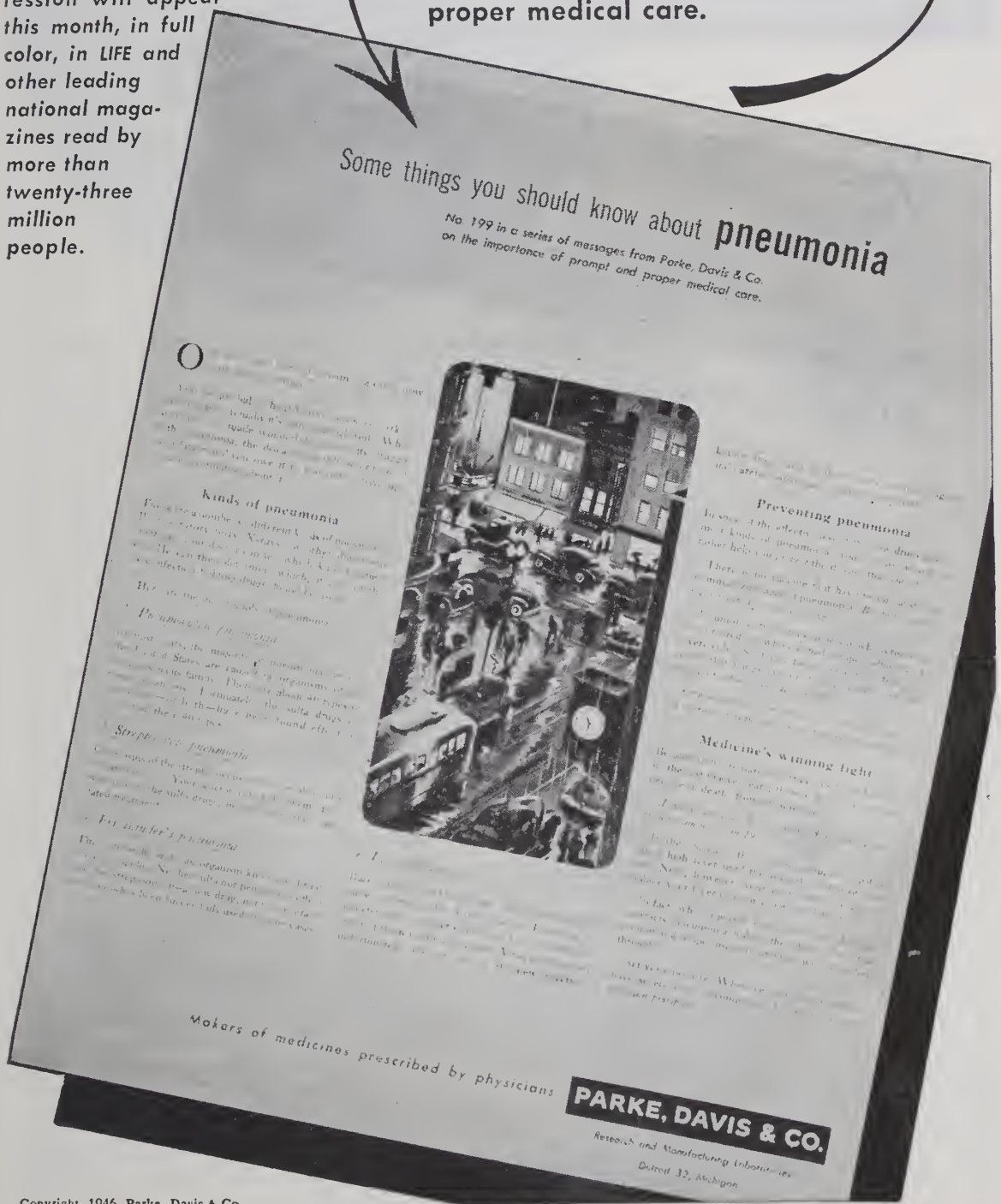
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OF
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Published Monthly Since September, 1904

Whole Number of Issues, 507

Under the
Direction of the
Committee on Publication

Henry C. Barkhorn, M.D., Chairman

Henry A. Davidson, M.D., Editor

Place of Publication, Printing and Mailing—12 South Day Street, Orange, N. J.
Editorial and Executive Offices of the Society—315 West State Street, Trenton 8, N. J.; Tel 5776
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Vol. 43, No. 11 November, 1946 **Subscriptions, $3.00 per Year**
Single Copies, 30 Cents

DOCTORS WITHOUT HOSPITALS

Except in a very few specialties, a doctor cannot practice medicine today without access to a hospital. This puts some of the younger physician-veterans in the difficult position of losing all major patients to their older colleagues or to those "essential" younger doctors who stayed home during the war and established hospital connections. Especially hard hit is the small but important group of physicians who entered service directly from internship or residency. They are not helped by the rank-freezing order which protected the staff appointments of doctors who already had hospital connections. Few institutions will give these young veterans a place on the courtesy staff. As a result, the doctor in such a position has no place to take a maternity case and is obliged to give up other patients who need hospitalization; or he is forced to try to treat such patients at home. No one seems to be doing anything about the plights of these hospital orphans.

The only practical solution is a deliberate and cooperative arrangement among the hospitals of New Jersey whereby each institution will arbitrarily accept two or three such veterans. Distributed in this way, the entire contingent—aggregating perhaps 150 or 200 physicians—can be absorbed without seriously disturbing any staff. If a hospital with 100 doctors on its list is already overstaffed, the increase of the number to 103 will not make much difference. Under such an arrangement, the veteran will not always have the hospital of his choice. Indeed, assignment will probably have to be made on a geographic basis. However, it will give him at least one institution where he can practice major medicine and remove one justifiable sore spot in our relations with demobilized doctors. Local Medical Societies can not initiate or implement such a plan. The hospital associations can do so, and their action in this direction will win the accolade of the organized profession throughout the state.

OPEN SEASON FOR MEDICAL MEETINGS

Now is the time for the officers to decry the poor attendance at the scientific and business sessions of our medical societies. While some of this truancy is due to crowded office hours, much of it represents a flight from boredom. Business meetings too often seem dull and the rank and file member feels that his only role is to join in the chorus when the chairman says: "All in favor say aye". And many a physician foregoes a scientific program because he feels he can read the paper when it is published and read it at his leisure without danger of ennui or somnolence.

Responsibility for providing an interesting meeting usually rests on the shoulders of the president, the secretary or the program committee of the society. For a scientific session, the tendency is to select a physician or surgeon of maximum eminence in the hope that the big name will serve as a magnet. Unfortunately many doctors who are brilliant in the operating room are poor performers on the platform. The man who wins a blue ribbon for medical research may be far more at home in the laboratory than in the lecture hall. It would be well if the officer responsible for selecting a speaker were to consider the guest's tutorial skills, his platform presence, and frequently his sense of humor, as well as his scientific attainments.

Another factor in poor attendance is the fear that the officials and speakers will not keep faith with the members with respect to the announced time-table. When meetings were scheduled at 8:30 p. m., doctors, certain that they would start a half hour late, did not arrive until 9 p. m. Observing this, the committee began scheduling the meetings at 9 p. m., with the result that the members did not arrive until 9:30. A society officer who seriously adheres to his announced schedule, can start the meeting promptly when announced, even though only a handful were present. This might be embarrassing the first time but when the members drift in in the middle of the talk they will realize that here at last is a president who means what he says when he announces a meeting for a certain time. The larger societies could well learn something from the smaller organizations which so often draw maximum attendance. One reason is that an atmosphere of camaraderie is introduced by the genial custom of having a dinner before or a collation after the meeting. Another is the practice of calling on as many of the members as time will permit to participate in the discussion.

Officers responsible for the program might also give more thought to the attractiveness of the announced topic. Obviously a county medical society should set its sights at the general practitioner and, therefore, it would be a mistake to present a subject of highly specialized interest. Furthermore, most members are engaged in bedside practice and consequently a talk on treatment is more attractive than a lecture on pathology or etiology. Another attendance-catching device is to sprinkle the schedule with an occasional non-scientific program. Doctors are citizens and as such it should not be undignified or inappropriate if the meeting is occasionally devoted to a civic topic.

Every new president, secretary or program chairman who assumes office starts with high hopes that in his year an attendance record will be established. Careful planning and weighing of some of these factors would go far towards meeting that hope.

INDOCTRINATION OF MEDICAL SOCIETY MEMBERS

Southern California, that ever-active home of novelties and oddities, earns the spotlight again by a new "indoctrination plan" for candidates for membership. The idea seems to be that physicians should not be admitted to the county society until they have established the fact that they are "right-thinking" on matters of medical economics, ethics, and jurisprudence. The Los Angeles County Medical Society, third largest county medical unit in the country, now requires each applicant to pass an examination in "professional ethics, malpractice prophylaxis, courtesy, the Association's accomplishments and aims and other essential subjects". Presumably economics is included under the heading of "other essential subjects". In preparation for the examination, the candidate for membership attends a course in those topics. The ultimate aim, according to *California and Western Medicine* (March 1946) is to "establish a means through which doctors may be contacted and put in better harmony with changes now taking place. County medical societies also have the obligation to demand that all physicians whom they admit into membership shall have not only proper scientific and ethical qualifications, but also an adequate understanding and outlook on medical organization, economics and public relations."

The experiment will be observed with interest. If in fact, the "indoctrination courses" succeed in pressing all physicians into the same mould of organizational and economic thinking, future meetings of the Los Angeles society should become veritable love feasts. The vigorous differences of opinion on administrative and economic problems which add spice and interest to our own meetings, will presumably be lacking in that land where even the weather is balmy. Only one thought troubles us. Suppose some churlish fellow, tainted with economic and administrative ideas that are anathema to the high command, should also be smart enough to give the "right" answers at the examination? After all, even in California, a man can answer with his tongue in his cheek. What happens then? Probably, even this is no problem to the ingenuity of those who live under the spell of Hollywood. Thought control is just around the corner.

THE NEW CONVERSION TABLE

Elsewhere in this issue, we print in full the new metric-apothecary conversion table, oriented to the metric rather than to the apothecary dosage. A copy of this table, printed on cardboard, is available to all physicians on request, as indicated on page 471. It seems probable that from now on, all new drugs will be packaged according to metric dosage units.

It is requested that in manuscripts submitted to this JOURNAL, both metric and apothecary units be used, one in the main text, the other immediately following in parentheses. Dr. Lawrence's article in this issue illustrates the proper form for presenting both dosages. See page 452 for example. The Publication Committee has made no rule as to preference, and authors are free to use either system as the primary one. However, the table on page 471 will be used as the "official" basis for converting from one system to the other. It is desirable to express doses under 0.1 Grams in the form of milligrams. Thus, 50 milligrams is better than 0.05 Grams. To avoid confusion with "grain," capitalize the initial letter of "Gram". Such capitalization is not necessary for "milligram" or "kilogram".

ORIGINAL ARTICLES

RELAPSING TROPICAL DISEASES AND THEIR TREATMENT*

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Recently there has been much discussion concerning the place tropical disease will assume in medical practice in the United States. Some take the stand that, with the prevailing means of control, there will be little to worry about. Although many returning veterans and civilians may be infected, spread will be difficult, and in time, even those who are infected will become comparatively innocuous. Others hold that, as a result of increasingly fast travel, infected persons entering a new area will act as reservoirs of disease. Moreover, since most of our States possess adequate vectors, especially the fly and the mosquito, we face the possibility of introducing new diseases to this country. Thus a grave situation will result from epidemics of diseases now under fair control. Both views are, to a degree, correct.

Only by the diligence and foresight of the more advanced communities in this country has good sanitation been instituted and control measures taken against insects and other possible vectors. Only thus have widespread epidemics of so-called tropical disease been avoided. In my opinion, such measures have largely eradicated, or at least made minimal, the vectors of tropical disease.

If, however, we here in the United States were to relax our sanitary standards and our insect and rodent control, we might be swept by epidemics of cholera, yellow fever, plague, amebiasis and most of those diseases that, in general practice, we now consider rare. Here is an example. In 1946, up to the first of May, New Jersey health authorities had already reported 401 cases of malaria; whereas in all 1945 only 99 cases were listed. This marked increase is partially due to returning military personnel; also perhaps in part to the tardiness of certain communities. It is essential that practicing physicians be re-instructed in those diseases that threaten to become more prevalent on this continent, and which, up to now, through lack of interest, have largely escaped diagnosis and been allowed to spread insidiously through the population. Therefore, the purpose of this paper is to call attention to relapsing fevers which are more frequently encountered in the tropics but which are endemic in this country and may assume more importance in the future through the return of veterans and through post-war world travel.

CLASSIFICATION

These diseases may be divided into (1) those resulting from protozoa, such as malaria, amebiasis, leishmaniasis, and trypanosomiasis, (2) those from helminths such as filariasis and schistosomiasis, and (3) those resulting from bacteria, such as bacillary dysentery and brucellosis. Brucellosis and undulant fever are more prevalent in the United States than in the tropics. Diseases resulting from rickettsial or virus infection such as typhus and yellow fever are of no concern to us here since they are acute in nature and offer little hazard for the future, because they have no tendency to relapse.

EARLY DIAGNOSIS

The cardinal symptoms in this group of diseases are either fever or diarrhea, or both. In large part, the diagnosis can be definitely made only in the laboratory. Microscopy therefore assumes major importance. It is imperative for the practicing physician to realize that such diseases exist; and that, in order to reach a correct diagnosis, he should not only take all measures at his command, but also make full use of diagnostic laboratories. The New Jersey Department of Health offers the physician a full service in this respect. A detailed history is essential. Actually the tropical locality in which the person was domiciled may be a real clue to

* Read at the Annual Meeting of The Medical Society of New Jersey, Atlantic City, May 22nd, 1946.
† From the Department of Medicine, Cornell University.

diagnosis. By ascertaining the localities visited, certain diseases are automatically ruled out and others take on definite probability. For example, a person returning from Hawaii and complaining of chills and fever is not likely to have malaria, but he might be infected with one of the other diseases endemic on that island and presenting the same symptoms. The duration of stay and the probability of exposure are also important factors. Thus we had many thousands of troops in Assam, a highly endemic area for filariasis. Duration of stay was long, but exposure was minimal since the camps were well removed from Indian villages. On the other hand, many troops billeted in the Calcutta area were there for only a short time but exposure was maximal since several camps were situated in the immediate environs of mosquito-ridden Indian houses where 10 to 20 per cent of the inhabitants were infected with microfilariae in the circulating blood. Coggeshall [1] reports 10,421 cases of filariasis in the Marine Corps and in the United States Navy alone as of December 1st, 1945, mostly as a result of close proximity to native communities.

MALARIA

Malaria is truly a global disease and potentially the most serious and the most common with which we have to deal. Until 1880 the disease was endemic throughout the United States; even today about a million cases occur annually with some five thousand deaths. Mackie [2] points out that with the present speed of travel, individuals can easily be transported within the incubation period of the disease, adding greatly to our problem. Authentic cases of spread as a result of chronically infected soldiers have been reported in Oregon [3] and in the upper Mississippi basin and in Iowa [4] where the incidence of malaria rose from 24 cases in 1935 to 250 cases in the first six months of 1945. Dr. H. S. Martland tells me that in Essex County, New Jersey, 26 cases of malaria due to Plasmodium vivax (all occurring in returned ex-service men) were reported to the Department of Health between January and May, 1946.

The disease is characterized by chills, fever, anemia and splenomegaly and is a profound parasitemia with parasitic destruction of the red blood cells. The commonest parasites encountered are: (1) *Plasmodium vivax* or benign tertian malaria, (2) *Plasmodium malariae* or quartan malaria, and (3) *Plasmodium falciparum,* or malignant tertian malaria. Relapses are common, particularly in the benign tertian form (30 per cent) and may persist for several years. Malignant tertian malaria has less tendency to relapse (8 per cent) but is far more dangerous, since it often invades the brain (cerebral malaria) and other vital organs, causing death, at times, within the space of a few hours. Relapses are far more common under the adverse conditions of exposure, chilling, fatigue, injury and infection. In the presence of pneumonia or any acute upper respiratory infection, an explosive relapse of malaria may confuse the picture.

In benign tertian malaria the young corpuscles, particularly the reticulocytes, are attacked. In malignant tertian or falciparum malaria, not only are all corpuscles attacked, old and young (which accounts for the high parasitemia), but clumping of the red cells is also produced. This peculiarity of the falciparum malaria produces thrombotic phenomena in capillaries and in larger vessels, provokes ischemia and anoxemia and makes the disease extremely dangerous to life.

The diagnosis and identification of the species of the malarial parasite is accomplished by either the thin or thick blood film. For thin smears, Wright's or Giemsa's method of staining is satisfactory. For thick smears, the drop of blood is hemolyzed and stained with methylene blue and eosin. The latter technic is useful in diagnosing light infection. The more recent method of staining by Field's technic is often of advantage. The New Jersey Department of Health will gladly do this. Treatment is directed toward eradication of the parasite from the blood and prevention of relapses. Suppressive therapy, used during the war, was of great advantage but to us in the United

1. Coggeshall, L. T.: "Filariasis in the Serviceman." J. A. M. A., 131:1 (May 4) 1946.
2. Mackie, T. T.: "War and the Migration of Tropical Diseases." J. A. M. A., 122:1 (May 1) 1943.
3. Osgood, S. B.: "Malaria and the Returning Soldier." J. A. M. A., 128:7 (June 16) 1945.
4. State Department of Health of Iowa: J. Iowa M. Soc., 35:331, August, 1945.

States, in cases of relapse it is of little value. Patients suffering from falciparum malaria should be hospitalized and others treated at home in bed for the duration of the attack. Fluids should be plentiful and the diet as tolerated. Liver and iron may be used to combat anemia. The present antimalarial drugs leave much to be desired. None of them can truly be called curative. Atabrine (Quinacrine hydrochloride, USP XII) is the drug of choice at the present time. To raise the blood concentration to an effective level 0.2 Grams (3 grains) of atabrine are given every six hours for five doses, followed by 0.1 Gram (1½ grains) three times daily for six days. In the event of a relapse, the same therapy is instituted or the 0.1 Gram dose continued for two or three weeks.

If quinine sulphate is used, it should be given in a dose of 0.6 Grams (10 grains) three times daily for three to four days, depending on the symptoms, and followed by 0.6 Grams every night for eight weeks. We utilized this regimen in India and it was our feeling that the number of patients who relapsed were fewer than among those in whom atabrine was used.

Plasmochin was used extensively by the British Army in Burma. A dose of 0.01 Gram (1/6 grain) three times a day for five days was given with fair results and few disastrous effects. The drug is specific against gametocytes and follows the administration of atabrine or in conjunction with quinine. In our routine, this drug was not used for treatment, since it is not only extremely toxic and, at times, dangerous but seems to be of little value in the prevention of relapses.

Virtually the only indication for parenteral therapy in malaria is a case of falciparum infection accompanied by pernicious vomiting or cerebral involvement with coma. Melaney [5] further advises its use if the parasite count is over 50,000 per cubic millimeter of blood or if the symptoms are out of all proportion to the parasitemia. Atabrine dihydrochloride in a dose of 0.2 Grams (3 grains) dissolved in 10 cubic centimeters of distilled water is administered intramuscularly and repeated in six hours if necessary. Oral treatment should commence as outlined above as soon as is feasible. Quinine dihydrochloride, if used, should not be given intramuscularly since tissue necrosis is often extensive. The intravenous route is preferable and a dose of 0.5 to 1.0 Gram (7½ to 15 grains) diluted with 200 cubic centimeters of normal saline, glucose or plasma is given slowly. In the event of a marked drop in blood pressure or rise in the pulse, adrenalin should be administered.

BLACKWATER FEVER

This is regarded as a complication of falciparum malaria and is characterized by sudden intravascular hemolysis with liberation of oxyhemoglobin in the plasma. It may prove rapidly fatal often as a result of anuria. The patient should remain at absolute rest; chilling is avoided, and all measures are taken to prevent or treat anuria. Mepacrine 0.1 Gram (1½ grains) daily and increased slowly to 0.3 Gram (5 grains) daily is probably the drug of choice.

THE DYSENTERIES

Although amebic and bacillary dysentery are classed as tropical diseases, they are really world-wide in distribution. Their spread requires no intermediate host, dissemination taking place by means of contaminated water, food or flies. The symptoms of both these diseases and non-specific diarrhea are often so similar that differentiation can be made only by the microscopic examination or culture of the stool. All cases of diarrhea in returned soldiers and in civilians who do not respond promptly to empirical therapy must be approached with grave suspicion and the utmost concern if we are to stamp out these diseases or keep them under control. The routine gross and microscopic fresh stool examination cannot be overemphasized. The fact that untreated early cases of amebic or bacillary dysentery tend to become chronic (and often lead to lifelong invalidism) should in itself be reason enough for thorough diagnosis and early institution of adequate therapy. At the Southeast Asia Command Air Force Headquarters in Calcutta [6] we observed that in 198 consecutive

5. Meleney, H. E.: "Problems of Treatment of Tropical Diseases in Returning Military Personnel." New York State J. Med., 44:2105-2108 (Oct. 1) 1944.
6. Lawrence, E. A., and Bennett, R. E.: "A Study of Diarrhea Occurring at AAF Headquarters, Calcutta, India." J. A. M. A., 129:3 (Sept. 15) 1945.

cases of diarrhea occurring in army personnel, 52.5 per cent were due to acute amebic or bacillary dysentery or both. To determine the carrier incidence of these diseases, large series of Indians and army personnel were selected at random and the stool examined microscopically and cultured by means of the rectal culture tube method. Results were astounding. It was found that 10 per cent of our personnel were carriers of one or another strain of bacillary dysentery, whereas only 3 per cent of the Indians were carriers; of our Command 3 per cent were amebic carriers; among natives, only 7 per cent. It was disconcerting to find such a high carrier rate in our troops who had in all probability transported one or the other disease from this country to the tropics! It has been estimated that some 10 per cent of the entire population of the United States are carriers of amebic dysentery; a figure no doubt so high as a result of the greater incidence in the Southern States but nevertheless alarming.

AMEBIC DYSENTERY

Amebic dysentery is an endemic disease caused by Entameba histolytica, and having an incubation period of from 20 to 90 days. Onset is insidious, fever is low-grade or absent, and the course is prolonged. Amebic hepatitis or abscess is the common complication; death may ensue as the result of intestinal perforation, hemorrhage, or embolic abscess. There is a generalized abdominal tenderness but tenesmus is not accentuated. Pathologically, the lesions are confined solely to the large intestine and consist of ulcers of the submucosa distributed in the long axis of the gut—the so-called flask-shaped, collar-button or *Bouton de Chemise* ulcer. There is no inflammatory reaction. If a large vessel is entered by the vegetative forms, massive hemorrhage by rectum may result; or the forms may enter the circulatory system and migrate, in large numbers, to the liver, lung or brain, giving rise to abscess. If all the walls of the intestines are traversed, performation may ensue and generalized peritonitis intervene. The stool, grossly, is fecal in nature, intermingled with blood and mucus, resembling anchovy sauce (sago grain stool). It is usually acid, copious, and has the offensive odor of decomposed blood. Charcot Leyden crystals are often seen. Superimposed bacillary dysentery is not uncommon.

The treatment of this disease is specific, and if started early, highly effective. Emetine hydrochloride is the drug of choice against the active form of the parasite and should be given in a dose of 0.06 Gram (1 grain) daily intramuscularly or subcutaneously until all symptoms are controlled, which usually requires from six to eight injections. No more than twelve injections should be given because of the toxic effects of the drug. I cannot agree with some [7] that emetine should be used only if blood is detected in the stool or if more than one distinct attack of diarrhea has occurred, or if the present attack has gone on for two months or longer. After all, we are attacking an invading organism. I do not recall, for example, any case of acute amebic dysentery in the Far East in which blood could not be detected microscopically or grossly in the stool. Emetine alone by injection will rarely sterilize an infection. The parasite, incidentally, may become drugfast and, therefore, the use of emetine should be limited to the control of acute symptoms such as fever, severe abdominal pain or involvement of the liver. Patients receiving emetine should remain in bed to avoid possible emetine syncope. In China and India, we followed the emetine injections with carbarsone 0.25 Gram (4 grains) three times a day for ten days and, finally, wound up with diodoquin, 0.6 Gram (10 grains) three times a day for 21 days. Some question has been raised about the toxicity of carbasone. In more than 200 cases treated with this drug we observed only one case of mild arsenical dermatitis. It has been further suggested [7] that in the uncomplicated case, diodoquin alone was sufficient to produce cure. We were never of the opinion that diodoquin by itself produced any such remarkable result; in a number of cases, cysts continued to be passed. The British Medical Corps were so impressed with the chronicity of the disease and their inability adequately to treat the initial attack that they used routinely two divided courses of emetine, a

7. "Conferences on Therapy, Cornell University Medical College and the New York Hospital." New York State J. Med., 45:21 (Nov. 1) 1945.

course of emetine bismuth iodide, and a course of chiniofon 0.25 Gram (4 grains) three times a day for ten days, together with enemata (2.5 per cent) of the same drug. The treatment of amebic hepatitis is essentially the same as for the acute colitis. Hepatic abscess, which may occur soon after, or as long as several years after the acute relapse, is treated by aspiration, concomitantly with the administration of amebicidal drugs. Liver abscess occurred in about 3 per cent of all cases of amebiasis treated at the Calcutta School of Tropical Medicine and was associated in 10 per cent with jaundice and impaired liver function.

Supportive treatment includes a high vitamin, high caloric diet, the usual therapy for secondary anemia if indicated, and no laxatives that may interfere with the amebicidal action of the drugs.

Amebic "carriers" may be treated with either carbarsone or diodoquin in doses advised above.

BACILLARY DYSENTERY

Bacillary dysentery is caused by invasion of the intestines by one or more of the many strains of the Shigella group of organisms. The incubation period is short, often less than seven days, and the onset usually acute, with fever and generalized abdominal tenderness associated with marked tenesmus. With the use of sulfonamides, the death rate was extremely low during the war. Pathologically, there is an acute diffuse necrosis of the mucous membrane of the large and occasionally small intestine. This necrosis leads to widespread sloughing of the gut and later ulcerations which are serpiginous, ragged, with undermined edges, and often extremely extensive. It is essentially an inflammatory reaction.

The treatment most frequently employed was sulfadiazine in a dose of 2 Grams (30 grains) initially, and one Gram (15 grains) every four hours, for three to five days, a total of 19 to 31 Grams (5 to 7½ drams) depending upon the severity of the disease. In the treatment of the Sonne strain, sulfaguanadine is probably more efficacious. The carrier state is treated in the same manner.

8. Culbertson, J. T., et al.: "Chemotherapy of Human Filariasis by Administration of Neostibosan." American J. of Trop. Med., 25:177-292 (May) 1945.

FILARIASIS

Filariasis is caused most commonly by the helminth Filaria bancrofti and is a chronic disease manifested at first by recurrent local pain, swelling or redness of the arm, leg, scrotum, or its contents; later with swelling of the regional lymph nodes and associated lymphangitis. Eosinophilia is present in about 60 per cent of all cases (an eosinophilia up to 3 per cent in the tropics is considered normal). Patients who have had a limited number of bites from infected mosquitoes never progress further than these initial symptoms. The severity of the symptoms is dependent upon the number of adult worms present in the human body. Patients exhibiting the revolting picture of elephantiasis or lymph scrotum are those who have been continually exposed to the bites of infected mosquitoes over a long period of time. Filariasis, like one or two other diseases, disappears in the individual for three reasons: (a) the microfilariae cannot reproduce without a vector; (b) the death of the worms; (c) the absence of the vector. Treatment of the relapse is purely palliative; elephantiasis is, however, an exception. Surgery is a possibility here. As far as general treatment is concerned, it is important to remove the patient from the area. The trivalent antimony preparation, anthiomaline, and also fuadin have certain value. Neostibosan has given encouraging results with respect to decreasing the number of microfilariae in the peripheral blood.[8] Coggeshall[1] and others see little chance of this disease ever becoming established in this country.

LEISHMANIASIS

Under leishmaniasis, at least three diseases are included: (1) *L. donovani,* known also as kala azar, visceral leishmaniasis, or dum-dum fever, (2) *L. tropica,* or cutaneous tropical sore, (3) *L. braziliensis,* or mucocutaneous leishmaniasis, or espundia. The parasites of kala azar attack the reticulo-endothelial system, particularly the reticulo-endothelial cells of the liver, spleen and bone marrow. Only the skin is involved in tropical sore and espundia. We are primarily concerned with the visceral form caused by *L. donovani,* which is characterized by chronicity, irregular and often dou-

ble daily rise of fever, hepato-splenomegaly, leukopenia, prostration and often protruberance of the belly.

Treatment of the cutaneous and mucocutaneous leishmaniasis is either by the local use of 2 per cent ointment containing antimony and potassium tartrate or local injection of berberine sulphate (2 to 3 cubic centimeters of the 1 per cent solution). If severe, fuadin in a dose of 5 cubic centimeters intramuscularly, biweekly for eight weeks, is efficient; or in its place neostibosan may be used.

In the treatment of kala azar, neostibosan is the least toxic of the pentavelent preparations and contains 40 per cent antimony. It is administered intravenously in a dose of 0.2 Gram (3 grains) on the first day, 0.4 Gram (6 grains) the second day, 0.5 Gram (7½ grains) the third and the same dose daily for from 12 to 24 injections. In children, solustibosan may be used and given intramuscularly.

Diamidine compounds, due to their toxicity, should be used only for patients who are antimony resistant. The dosage is 1 to 2 grams per kilo of body weight.

SCHISTOSOMIASIS (BILHARZIASIS)

Schistosomiasis is caused by trematodes or blood flukes. The three main types are: (1) *S. haematobium,* found in the north and east coast of Africa, which has a predilection for the bladder, the ova passing out in the urine, (2) *S. mansoni,* common in Egypt, East and West Africa, South America, and in some of the Carribean Islands, which has a predilection for the mesenteric veins and produces lesions in the large intestine, (3) *S. japonicum,* found in the Far East, and the islands of Japan, which has a predilection not only for the mesenteric veins of the small intestine but also the portal circulation giving rise to hepatic disease, profound enlargement and later shrinkage of the liver (cirrhosis) and spleen (Egyptian splenomegaly).

Symptoms are not produced by the adult worms since they live in the lumina of the vessels but by the eggs deposited in the mucosa. The diagnostic criteria in the first stages of this disease are fever, urticaria, abdominal discomfort and a profound eosinophilia as high as 75 per cent. Later, when eggs begin to appear in the stool or urine, the passage of blood is often copious. The blood serum globulin is markedly increased. Finally, cirrhosis of the liver may result and follows its classical course. Metastatic complications in all types are not uncommon.

The treatment is highly effective in the acute active cases, less so among patients whose disorder has become chronic due to subsequent tissue damage. Tartar emetic has been replaced almost entirely by fuadin, which is given intramuscularly as follows: 1.5 cubic centimeters on the first day, 3.5 on the second day, 5 on the third day, and the same dose every other day for five injections. A second course of five injections should be given if ova are still found several weeks after the initial treatment.

SUMMARY

We shall see a definite increase in the incidence of dysentery and malaria through the United States, introduced by veterans and future travellers. It is imperative to organize diagnostic laboratories with trained technicians for the use of physicians. Every effort should be made, on the part of doctors, to diagnose cases early and institute adequate therapy in order to hinder spread in regions where vectors are present. It seems highly unlikely that the lesser known diseases will ever become important to us in this country except where the incubation period is long. If the practicing physician and public health authorities work as a team, these diseases can, in truth, be confined to the countries from which they came, thus happily reaffirming, in a medical sense, Kipling's optimistic assertion that "East is East and West is West, and never the twain shall meet."

33 East 61st Street

TRAUMATIC INTRACRANIAL ANEURYSM WITH PULSATING EXOPHTHALMOS *

By OTTO R. HOLTERS, M.D., JAMES A. FISHER, M.D., and JAMES A. FISHER, JR., M.D., Asbury Park, N. J.

The general practitioner rarely sees a case of traumatic intracranial arteriovenous aneurysm. In fact, Martin and Mabon [1] were able to collect only 812 cases in a thorough review of the literature. It is therefore of interest to place on record this case in which surgical intervention successfully controlled the symptoms and prevented extension of the aneurysm.

ANATOMIC FACTORS

The anatomic relationship between the internal carotid artery and the anterior cerebral artery on one hand, and the cavernous sinus on the other, is such as to make this location extremely vulnerable in fractures of the sphenoid bone. These fractures are not always visualized by x-rays. The paralytic eye signs which result from such injuries are explained by the relationship of the cavernous sinus to the superior orbital fissure and the pathways of the oculomotor, trochlear, ophthalmic division of the trigeminal nerve, and the abducens nerve. The latter run within the medial wall of the sinus.

SYMPTOMATOLOGY

Cardinal signs and symptoms of this type of arteriovenous aneurysm are intracranial bruit, pulsating exophthalmos, chemosis of the conjunctiva, headache, diplopia and other visual disturbances.

The case history is of utmost importance. Every detail of the subjective symptoms observed by the patient must be noted. The chronologic order of the development of the symptoms is a valuable diagnostic clue. In the following case, an error on the part of both patient and doctor caused us to miss the diagnosis at the first admission. The error was the patient's failure to mention the fact that head noises had been present since the injury. This omission, together with absence of early pulsation in the exophthalmos, diverted our attention from the logical diagnosis.

CASE REPORT

Mrs. D. H., white female, age 42, was admitted to Fitkin Memorial Hospital on January 14, 1946, complaining of severe headaches and visual disturbances. She had previously been admitted to the hospital in November, 1945, for pelvic surgery following which she occasionally had mild attacks of vertigo.

Present illness began on January 6, 1946, when she fell from a stool, striking the right side of her face and head. She was found by her husband in a dazed condition, walking about with bleeding from her nose. She recovered sufficiently to continue with her household duties. That evening she heard "the noise of a factory" in the neighborhood which she had never heard before. This noise persisted thereafter but is the one important point she failed to mention on this hospital admission.

Next morning she developed a severe headache which began with a shooting pain over the right eye and radiated to the back of the head. The same day she noticed that her right eyelid was drooping and that she had double vision. She attributed the swelling about the face and eye to the direct blow. She applied ice packs with no relief of the swelling or symptoms and was admitted to the Fitkin Memorial Hospital on January 14.

Upon admission, examination revealed a complete paralysis of the third nerve, partial paralysis of the fourth and sixth nerves, extreme proptosis and marked chemosis of the conjunctiva. Roentgenograms of the skull and orbits revealed no demonstrable fracture. Vital signs were negative with the exception of an increase of the pulse rate to 100. All laboratory work was negative.

Consultations: She was seen by Dr. Raoul Pietri and Dr. James A. Fisher, Sr., who agreed on the paralysis of the extrinsic occular muscles but failed to find any evidence of disc changes in the eyes or any evidence of venous pulsation. First impressions were that a massive orbital hemorrhage had occurred at the apex of the orbit. The patient was allowed to go home on January 30 to await further developments. Two weeks later she was seen in the office of the ophthalmologist, Dr. Fisher, at which time pulsation of the exophthalmos was noted. Her physical signs had increased in the right eye and similar signs to a lesser degree were developing in the left eye. She was again referred to the hospital for admission where examination showed the above findings. Now a loud bruit was heard over the right frontal and temporal regions which entirely disap-

* Presented to the Staff Conference, Fitkin Memorial Hospital, Neptune, N. J., on February 28, 1946.

1. Martin, J. A., and Mabon, R. A.: Journ. Amer. Med. Assn., 121:5 (Jan. 30, 1943).

peared when the carotid artery was compressed. Further consultation among Drs. Holters, Pietri and Fisher arrived at the diagnosis of arteriovenous aneurysm between the internal carotid artery and the cavernous sinus.

Treatment: Compression of the carotid artery was started with a gradual increase in time until the patient could tolerate 30 minutes of compression without cerebral symptoms.

Operation: On February 19, under pentothal-sodium anesthesia, a double ligation of the right common carotid artery and the right internal carotid artery was performed with No. 7 braided silk as ligatures. One hour after operation it was noted that the bruit had entirely disappeared and that there was a marked decrease in both exophthalmos and chemosis on both sides. By next morning the eyes had regained most of their motility and the proptosis had practically disappeared. Two days later, the only remaining signs were a slightly larger palpebral aperture on the right than on the left, a dilated right pupil and diplopia only on right external rotation.

Post-operatively, her pulse increased to 120 and remained between 100 and 120 for the two weeks she remained in the hospital. Her blood pressure increased from 132/86 pre-operatively to 185/144 post-operatively. It gradually receded to 152/112 at the time of her discharge. A few days post-operatively the patient complained of a headache which started at the occiput and ran down the back of the neck. It was assumed that this was due to the increased blood volume carried by the vertebral arteries.

Results: Ten days after discharge there was still some slight passive congestion of the right conjunctiva and very slight protrusion of the right eye. There was no retinal pulsation and no bruit was heard. Vision in the right eye was 20/70, the left eye 20/30. The peripheral fields were normal in each eye but there was an increase in size of the normal blind spot in the right side.

SUMMARY

This case report is presented with the purpose of pointing up the early diagnosis of arteriovenous aneurysm. The diagnostic signs and symptoms are emphasized, namely, pulsating exophthalmos, intracranial bruit, chemosis of the conjunctiva, diplopia and other visual disturbances. The sequence of their appearance is stressed.

Operation by common and internal carotid artery ligation successfully controlled the extension of the aneurysm and relieved the patient of most of the distressing symptoms.

1002 Emory Street

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NARCOTIC COMMISSIOINER WARNS ON DEMEROL

Emphasizing the fact that demerol, a substitute drug for morphine, has habit-forming properties, H. J. Anslinger, Commissioner of Narcotics, writing in *The Journal of the American Medical Association,* says:

"Now comes an article by Paul de Kruif in the June issue of the Reader's Digest entitled 'God's Own Medicine—1946' under the headline 'The pain-fighting power of demerol is as miraculous as that of morphine—without the opiate's danger of addiction.' This article adroitly makes no reference to the work of Himmelsbach, Hecht, Noth and Yonkman, all of whom warned of the danger of addiction.

"Demerol was placed under federal narcotic control by the Congress because of evidence of its dangerous properties. Some of the persons referred to in de Kruif's article could have attended the hearings before the Ways and Means Committee and could have testified as to what they thought about the drug, but they elected to remain silent.

"I fear a wave of demerol addiction if physicians believe the reckless and dangerous statements made by de Kruif that the drug is free from addiction properties. This is information somewhat similar to that which appears in the circular distributed by the manufacturer of demerol to push sales. Had this article been prepared on a strictly scientific basis it would have sounded a strong warning about the danger of addiction. Our files contain numerous cases of addiction involving the use of demerol."

Demerol, also known as dolantin, was discovered in Germany and made its appearance several years ago in the Argentine. Both of these countries immediately placed the drug under strict control.

HEARTBURN IN PREGNANCY

DANIEL B. ROTH, M.D., Teaneck, N. J.

Heartburn is a common complaint in the last trimester of pregnancy and one which occasionally causes real discomfort to the patient. It is due to the regurgitation of gastric contents and has no relation, at all, to the heart. It is essentially a neuromuscular phenomenon.

CLINICAL PICTURE

The clinical picture is familiar to all who treat pregnant women. It appears in the last trimester and seems to be worse at night. Many women experience it only in a recumbent position and in some, the symptoms are severe enough to interfere with sleep. Once the patient has delivered there is rapid disappearance of the symptoms. It is usually not associated with organic disease and has been treated with many remedies of varying effectiveness. Rodney and Shelley [10] reported a study of 100 patients, 66 of whom complained of heartburn during pregnancy. Maximum discomfort appeared in the first four months in 15 per cent; in the fifth month in 20 per cent, in the sixth to eighth months in 47 per cent and in the ninth month in 18 per cent. Three-fourths of the women reported that they were relieved in the fortnight prior to delivery, independently, it seemed, of the therapy used. Seven per cent of the women who had heartburn developed toxemias, but later studies would seem to indicate that this finding was purely coincidental.

ETIOLOGY

Of prime etiologic importance is the hypomotility which is found at the later stages of pregnancy and involves both the cardiac sphincter and the lower end of the oesophagus. Experimental distention of the lower end of the oesophagus has been shown by Jones and Richardson [1] to cause the symptoms of heartburn irrespective of the type of fluid regurgitated. Experimentally warm or cold water, dilute solutions of acid or alkali, barium sulfate mixtures and even the subject's own gastric juice caused the symptoms when instilled into the lower oesophagus.

Williams [2] summarized the changes which take place in the stomach. As the pregnancy advances the enlarging uterus encroaches on the abdominal organs and forces the normally vertical stomach out of position. As a result, the gastric fundus lies under the left leaf of the diaphragm, the greater curvature lies near the cardia and the entire organ is rotated about 45 degrees to the right. These changes tend to hinder gastric emptying and help to set up waves of reverse peristalsis. Coupled with the increasing atony of the stomach, passage of gastric contents into the oesophagus is an easy matter.

While the above conditions usually exist without any organic lesions, Schnepp [3] has shown that a diaphragmatic hernia may be present which will cause an "intractable heartburn". Such hernias, he says, are found in two per cent of patients who are seen in general practice with conditions severe enough to bring them to roentgenologic examination. Evans and Bouslog [4] reported four cases of intractible heartburn which they showed to be due to herniation. After delivery, the symptoms disappeared promptly and the herniations could no longer be demonstrated.

Dwyer [9] found that the size of the hiatus could vary widely. He feels that all oesophageal hiatus hernias are congenital in origin and that they develop clinically as a result of increased intra-abdominal pressure or of trauma. In pregnancy, as intra-abdominal pressure increases, hernias can develop through the hiatus.

In many of the textbooks it is stated that heartburn is due to the regurgitation of acid contents into the oesophagus and for this reason alkalis have been used with variable success. Strauss and Castle [5] have shown that this is erroneous and that, in fact, the gastric acidity decreases as pregnancy advances and is at its lowest point during the third trimester when heartburn is most severe.

Dietary factors may also play a role. Tuft and Tumen [6] have found that in certain persons intolerance to fats and sugars causes

gastrointestinal symptoms. Rodway and Shelley [10] report that 33 per cent of their patients found that fatty or fried foods either brought on or aggravated the symptoms. With the changes which take place in gastric motility and gastric secretion it can be expected that such intolerance would increase and in these individuals the diet would be a factor in causing symptoms.

TREATMENT

A reduction of the fat in the diet with the elimination of fried foods is frequently beneficial. The diet should be rich in proteins and milk.

Prostigmine has been reported as a very efficient agent in this condition. This synthetic cholinergic drug acts well on the disturbed neuromuscular function of the stomach. Williams [2] used prostigmine methylsulfate intramuscularly in 0.5 milligramme doses and reported that fourteen out of sixteen women were relieved; the benefit lasted for as long as a week or ten days. Wiley [7] used prostigmine bromide orally in 15 milligramme tablets and reported complete relief in fifteen out of twenty patients and partial relief in two more. I observed similar relief in six out of seven women on whom I used the oral medication. The drug is best given in the evening and only on days on which the patient experiences symptoms. Relief is usually prompt and lasting; occasionally patients will require a second dose during the night.

Large doses of B-Complex are also efficacious. Hart [8] reported a series of cases in which he administered yeast, thiamine chloride and nicotinic acid to a group of women complaining of heartburn. Among sixteen women, twelve had complete relief, two had partial relief and two were unchanged. His best results were obtained among patients who received thiamine intravenously in 50 milligramme doses followed by 25 milligrammes daily by mouth for several days. In two cases there was a history of clinical pellagra and in these he found a low gastric acidity. Both the symptoms and the acidity improved rapidly on administration of thiamine with 200 milligrammes of nicotinic acid. He ascribed the increase in gastric acidity to the nicotinic acid. In my own experience, women who complained of paraesthesias of the hands and feet frequently complained of heartburn; and in these women large doses of thiamine chloride effected relief of the symptoms. The use of thiamine in heartburn is based on the observation that dysphagia and cardiospasm in non-pregnant persons can be relieved by this vitamin.

While it has been shown that these patients have lowered gastric motility and secretion, many women who have heartburn have obtained relief by using alkalis, such as bicarbonate or block magnesia. The effect of these alkalis must be largely psychic, a fact to be borne in mind in the evaluation of other remedies.

SUMMARY

Heartburn of pregnancy, an annoying complication of the third trimester, is due to gastric hypomotility and hyposecretion and, in a few cases, to diaphragmatic hernia. The most effective treatment is the administration of cholinerges (prostigmine), the use of thiamine chloride and nicotinic acid, and dietary management. How much of the therapeutic results are psychic is open to question in view of the unphysiologic improvement noted in many women following the administration of alkalis. Considering the evident benefit from prostigmine and vitamine B, further trial of these agents is definitely indicated.

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PANTOPAQUE MYELOGRAPHY: INDICATIONS AND TECHNIC

BENJAMIN COPLEMAN, M.D., Perth Amboy, N. J.*

So many conditions produce low back pain that a differential diagnosis from protruded intervertebral disc is difficult by clinical means alone.

Most cases (about 60 per cent) of protruded intervertebral disc can be detected by clinical examination, including study of the cerebrospinal fluid. This leaves a large number of patients with a lesion which is unrecognized; or if suspected, unproved. It seems unreasonable to deny these patients the benefits of a surgical cure. Without the certainty of a definite diagnosis few physicians will recommend, and few patients will submit to, a surgical procedure. In these cases, opaque myelography, an easily performed, harmless examination, is, in experienced hands, the only means by which a diagnosis may be established with a high degree of accuracy.

CLINICAL DIAGNOSIS

The clinical diagnosis is based on a history of trauma or back strain, followed by intractable pain in the back or legs, or both. In most cases, the back pain precedes the leg pain. The pain is frequently intermittent, and is not relieved by ordinary therapeutic measures.[1] The spinal muscles are usually spastic and motion is limited and painful. The straight-leg raising test (Lasegue) is frequently positive. The neurologic signs, which are usually minimal, consist of absence of, or a decrease in, the Achilles reflex, and variable areas of altered sensation. Total protein of the cerebrospinal fluid is often elevated.

While these symptoms and signs are considered by many to be characteristic of a protruded disc, Munro [2] has shown that other conditions may also produce them. He determined that the significant findings were (a) history of a fall or strain, (b) followed by intermittent attacks of pain which was (c) increased in intensity by coughing, sneezing, or straining. Also important were the presence of (d) leg atrophy, usually due to a protrusion at the fourth lumbar level and (e) the loss of the ankle jerk on the affected side, usually due to a protrusion at the fifth lumbar. In Munro's experience, muscle spasticity or obliteration of the lumbar curve, pain on pressure lateral to the spinous processes, a positive leg raising test (Lasegue), objective sensory changes, and cerebrospinal fluid studies were not characteristic or significant.

VALUE OF RADIOGRAPHY

The clinical examination should always be followed by a thorough and painstaking radiographic examination of the lumbosacral spine and pelvis. This examination may reveal evidence of tumor, arthritis, or anomalies such as spondylolisthesis as the cause of the patient's symptoms. Information concerning anatomic landmarks or variations will be of great value if an operation is necessary.

CONTRAST MEDIA

Many different contrast substances have been employed in myelography. *Air* or *oxygen* is useful when there is a complete spinal fluid block, or where the protruded disc is large. While staunchly advocated by a few, the consensus is that the accuracy and definition of air myelography are well below those of myelography with the opaque media. *Thorotrast* is not generally used because of the inconvenience encountered in its removal, and because of its radioactivity. *Lipiodol,* an excellent medium, has of late been supplanted by a freely flowing non-irritating substance called *pantopaque.*

PANTOPAQUE

Pantopaque is a stable, radio-inert, non-toxic solution. Once injected, it is easily removed in most cases. Where complete removal has been impossible, no reactions have resulted from its

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1. Echols, D. H.: Neurologic Aspects of Low Back Pain and Sciatica. J. A. M. A. 125:416 (1944).
2. Munro, D.: Posterior Herniation of the Lumbosacral Discs. N. E. Jour. Med. 232:149 (1945).

retention within the subarachnoid space.[3] It is absorbed slowly. Pantopaque is satisfactorily radio-opaque, and tends to maintain itself in a homogeneous column which readily fills the nerve sleeves.

TECHNIC

The patient is placed on the x-ray tilt table, head at the head end of the table, in the lateral recumbent position, as for an ordinary lumbar puncture. In this position, with the neck, trunk, and knees well flexed, and the shoulders in the same vertical plane, entrance of the needle into the subarachnoid space is recognized more readily than in the prone position which is generally recommended. After the skin is prepared, the tissues at the second or third lumbar interspace are injected with novocain down to the interspinous ligaments. When the spinal fluid flows freely, 3 cubic centimeters of pantopaque are injected firmly and steadily. If the injection is intermittent or hesitant, the opaque fluid may break up into globules. The stilet of the needle is replaced, and the patient is cautioned to turn slowly on to his abdomen. The soles of his feet should be placed firmly against the foot rest of the tilt table.

This procedure usually leaves a homogeneous column of the opaque material at the level of the third lumbar vertebra. The head end of the table is slowly raised so that the pantopaque will slowly descend in the spinal canal. The advancing edge is watched for slight deformities as each interspace is bridged. Spot fims are made in the antero-posterior and both oblique projections. The oblique views have been found to be more useful than the lateral. Each interspace is examined in this manner. After the cul-de-sac is investigated, each interspace is again observed fluoroscopically as the table is tilted from the erect to the horizontal or beyond. If persisting deformities are observed, spot roentgenograms may be made to show various phases of the development of the deformity. At the completion of the examination the table is tilted until the pantopaque collects beneath the point of the needle so that the opaque material may be withdrawn.

Experience has shown that the fourth or fifth lumbar interspaces are involved in about 95 per cent of the cases of protruded discs.[2] Therefore, unless there are signs or symptoms pointing to a lesion at a higher level, only the last three lumbar interspaces are examined. This avoids prolonged fluoroscopic exposure and the use of an excessive number of films.

The time required to perform a myelographic examination, including the initial lumbar puncture and the withdrawal of the pantopaque at the end has been about twenty minutes in the average case.

DISCUSSION AND SUMMARY

Nearly half of the cases of protruded intervertebral disc do not lend themselves to accurate diagnosis by clinical means alone. Many conditions produce low back pain with sciatic radiation. Without the use of opaque myelography it is difficult and often impossible to determine the exact level of the protruded disc, and whether it is single or multiple. In view of the very localized surgical attack on this lesion, this information is of great importance.

Not every disc lesion may be demonstrated by myelography. At the lumbosacral interspace especially, a disc lesion may not be revealed roentgenologically, yet may be discovered at the operation. On the other hand, many patients whose clinical findings offer little or no clue to the correct diagnosis are discovered on myelographic examination to have a disc protrusion as the cause of the symptoms.

A method is available to determine definitely in a high proportion of the cases whether a disc protrusion is present or not. This method, pantopaque myelography, is no more harmful in its execution or after effects than a diagnostic lumbar puncture.

3. Copleman, B.: Roentgenographic Diagnosis of the Small Central Protruded Intervertebral Disc. Amer. Jour. Roentgenol. 52:245 (1944).

STATE ACTIVITIES

TRUSTEES' MEETING—SEPTEMBER 29, 1946

A regular meting of the Board of Trustees was held Sunday, September 29, 1946, at the State Society Headquarters, Trenton.

Present were: Dr. Crowe, Chairman, who presided, Dr. Norton, Dr. Stahl, Dr. Johnsen, Dr. Coleman, Dr. Green, Dr. Hawkes, Dr. Schaaf, Dr. Alexander, Dr. Fithian, Dr. Dodd, Dr. Hornberger, Dr. Costello, Dr. Lee, Dr. Young, and Dr. Sica. Dr. Scammell was excused. Also present upon invitation were Dr. Barkhorn, Dr. Scott, Dr. Londrigan and Dr. Yorke. Minutes of the June meeting were read and approved.

Chairman Crowe appointed the following committees to draw up resolutions on the deaths of Dr. North and Dr. Eagleton:

For Dr. North: Dr. Hornberger, Chairman, Dr. Fithian and Dr. Stahl;

For Dr. Eagleton. Dr. Hawkes, Chairman, Dr. Alexander and Dr. Norton.

ELECTIONS

The secretary read a communication from the Mercer County Medical Society recommending the consideration of Dr. L. Samuel Sica of Trenton to fill the vacancy on the Board of Trustees from the 3rd District, caused by the death of Dr. Harry R. North.

Dr. Hornberger nominated Dr. L. Samuel Sica for membership on the Board of Trustees from the 3rd District. Seconded by Dr. Norton.

It was regularly moved, seconded and unanimously carried that the nominations be closed and that the Secretary cast a ballot declaring Dr. Sica elected to membership on the Board of Trustees from the 3rd District.

The Secretary read a communication from the Essex County Medical Society urging the consideration of Dr. J. Wallace Hurff of Newark as a Delegate to the American Medical Association, to fill the vacancy caused by the death of Dr. Wells P. Eagleton.

Dr. Schaaf nominated Dr. J. Wallace Hurff of Newark, for Delegate to the A.M.A. Seconded by Dr. Coleman.

Dr. Alexander moved that the election of Dr. J. Wallace Hurff as a delegate to the A.M.A. be declared unanimous. Seconded and unanimously carried.

Dr. Norton nominated Dr. L. Samuel Sica as a Trustee representative on the Finance and Budget Committee, to fill the vacancy caused by the death of Dr. Harry R. North. Seconded by Dr. Stahl.

Upon motion the nominations were closed and the secretary was directed to cast a ballot declaring Dr. Sica elected as Trustee representative on the Finance and Budget Committee.

Dr. Norton nominated Dr. Anthony J. Conty of Union City for membership on the Finance and Budget Committee from the membership at large. Seconded by Dr. Schaaf.

Upon motion seconded and unanimously carried, the nominations were closed, the secretary cast a ballot declaring Dr Anthony J. Conty elected to the Finance and Budget Committee from the membership at large.

Upon motion by Dr. Norton, seconded by Dr. Alexander and unanimously carried the Chairman was authorized to appoint the Audit Committee from the Trustees.

Chairman Crowe appointed the following:

Dr. William F. Costello, Chairman
Dr. Sigurd W. Johnsen
Dr. Joseph G. Coleman

FINANCE AND BUDGET COMMITTEE

Dr. Costello presented the following report for the Finance and Budget Committee:

In connection with the resolution from the Essex County Medical Society relative to the credit of dues for delinquent or new members honorarbly discharged from the Service, referred to the Finance and Budget Committee by the Trustees on May 24th, the Committee presented the following recommendation:

> That the State Society give a credit for 1946 dues to all honorably discharged veteran physicians in good standing in their respective county secieties, and to those not in good standing through clerical error in the office of the County Societies, upon re-establishing their membership in their county society within 90 days of discharge from the armed forces of the United States.

Following discussion, and upon motion by Dr. Schaaf, the following phrase was stricken from the recommendation: "within 90 days of discharge from the armed forces of the United States". The recommendation was then ap-

proved by the Trustees, upon motion by Dr. Hornberger, seconded by Dr. Coleman and unanimously carried.

The Veterans Liaison Committee will incur expense in connection with the incorporation of the county societies, and other matters pertaining to the work of the Committee. In view of this the Finance and Budget Committee recommended the following.

That the Board of Trustees authorize the transfer of funds to cover the expenses of the Veterans Liaison Committee, contingent on the receipt and approval by the Board of Trustees of a budget from that Committee.

Following a report by the Chairman of the Veterans Liaison Committee, Dr. Londrigan, this item was removed from the table upon motion.

Dr. Lee moved that the Finance and Budget Committee be authorized to set up a budget, not to exceed $4,000 for the current administrative year, for the use of the Veterans Liaison Committee, from the account known as A--. Seconded and unanimously carried.

Dr. Costello announced that Dr. David B. Allman of Atlantic City had been elected by the Finance and Budget Committee as its new Chairman.

It was directed that Dr. Allman be invited to attend all meetings of the Board of Trustees.

RECOMMENDATION ON INTERN TRAINING

Recommendation of the Committee on Intern Training was that a Joint Committee of the New Jersey Hospital Association and The Medical Society of New Jersey be created to make an exhaustive study of the whole intern situation as it affects New Jersey Hospitals.

Upon motion by Dr. Hornberger, seconded by Dr. Schaaf and unanimously carried, the above recommendation was approved.

Dr. Costello moved that the President of the Society be requested to appoint a committee to work with a committee from the New Jersey Hospital Association in studying the intern situation in this state. Seconded and unanimously carried.

RECOMMENDATIONS ON LABORATORY MEDICINE

The recommendation of the Welfare Committee that a Section on Clinical Pathology be established, was unanimously disapproved by the Trustees. The Trustees felt that it is not desirable to create new sections as they would detract from the general sessions; that the field of clinical pathology properly belongs in the Section on Medicine; that time and space are not available to accommodate a new section; but that the Section on Medicine will be requested to devote a part of its program to clinical pathology. The following recommendation was then considered:

The Trustees endorse the proposition that the Director of Laboratories of the State Department of Health should hold the degree of Doctor of Medicine and be a specialist in the practice of laboratory medicine.

In the discussion which followed it was stated that it was more desirable to endorse the *principle* of having medical doctors trained in laboratory work in charge of the laboratories of the State Department of Health and all other medical groups in New Jersey. Dr. Lee moved that the above recommendation be approved after the substitution of the word "principle" for the word "proposition" in the first line. Seconded by Dr. Stahl and unanimously carried. The following recommendation was then considered:

That the State Department of Health be advised that The Medical Society of New Jersey does not approve the practice of approving laboratories as such, but rather approve the director of a laboratory, who shall of necessity be a Doctor of Medicine specializing in clinical pathology.

Following discussion, and upon motion by Dr. Hawkes, seconded by Dr. Sica and carried, the matter was tabled.

AUXILIARY MEDICAL SERVICES

It had been proposed by the Welfare Committee that the report of the Advisory Committee on Auxiliary Medical Services, made by Dr. Sigurd W. Johnsen and printed in the May 1940 issue of THE JOURNAL, pertaining to the economic relationship between specialties of radiology, laboratory medicine, physical medicine and anesthesiology, be either republished or that a copy be sent to each individual physician in New Jersey.

Dr. Hornberger moved that the recommendation be disapproved. Seconded by Dr. Stahl and unanimously carried.

Dr. Johnsen explained that the principles set forth in the article have now been adopted officially by the American Medical Association. This action consisted of recognizing anesthesiology, clinical pathology, physiotherapy and radiology as specialties in the practice of medicine. Since these principles are now embodied in our medical program, he recommended that this matter be taken up with the Hospital Relationships Committee and the Joint Committee on Intern Training in an effort to promote better understanding and

working relations between physicians engaged in these specialties and the hospitals.

Dr. Costello moved that Dr. Johnsen's recommendation be concurred in. Seconded and unanimously carried.

FUNDS FOR THE STATE BOARD

The Welfare Committee had made the following recommendation:

That adequate funds be provided to the State Board of Medical Examiners, either through an annual registration fee or through the treasury of The Medical Society of New Jersey, for the proper enforcement of the Medical Practice Act.

Dr. Schaaf stated that the Board of Medical Examiners does not need additional funds for enforcement of the Medical Practice Act, and moved that the above recommendation be disapproved. Seconded and unanimously carried.

MEDICAL SERVICE ADMINISTRATION

Dr. Scott presented a statistical and financial report on the Farm Security Plan, the City of Newark Medical Plan, the Veterans Plan, and the Medical-Surgical Plan. Copies were distributed to the members of the Board and one is on file in the Executive Offices.

Dr. Schaaf moved that the proposal to raise income limits for subscribers to Medical-Surgical Plan be approved in principle by the Board of Trustees. Seconded by Dr. Young and unanimously carried.

OTHER RECOMMENDATIONS OF THE WELFARE COMMITTEE

The Welfare Committee had recommended that the interpretation of section 45:9-18 of the Medical Practice Act, as to its applicability to persons without medical degrees practicing laboratory medicine, be referred to the State Board of Medical Examiners. The Trustees endorsed this recommendation.

The recommendation that the Society publish a list of physicians in New Jersey according to specialty was tabled.

The nomination of Dr. Henry Coit as the New Jersey physician whose professional activities would best lend themselves to radio dramatization during the A.M.A.'s nationwide program, was unanimously approved.

The Advisory Committee on Workmen's Compensation was authorized to prepare for the JOURNAL a revision of its article on workmen's compensation which originally appeared on page 453 of the September 1941 JOURNAL.

The Chairman of this committee was also given authority to act in implementation of a recommendation that fees for compensation cases be placed on a par with fees charged private patients and with the fee schedule of the Veterans Administration.

The Trustees also authorized purchase in bulk of the Tristate Medical Directory to permit resale to our members at the discount available for pre-publication orders.

STATUS OF OSTEOPATHS

Dr. Schaaf moved that this Society "declare its policy in relation to fully licensed doctors of osteopathy to be full cooperation short of membership in a component society". This motion was defeated, but the Trustees voted to appoint a committee to study the subject.

VETERANS LIAISON COMMITTEE

Dr. Londrigan, chairman of the committee, presented Dr. Edward T. Yorke, Veterans Liaison Officer, to the members of the Board. Dr. Londrigan reported that the Committee has made contact with each county society relative to the setting up of local examination units. Counsel has been engaged for the purposes of incorporating each county society so that contracts could be made with Veterans Administration. Monmouth County has already signed its contract and Hudson and Essex will soon be ready to negotiate. Arrangements have been made with the International Business Machines to do all paper work in connection with the operation of these units, if the county societies so desire it. In order to sell the services of IBM to the county societies it will be necessary for the Board of Trustees to permit the formation of a corporation to make contracts for the county societies. The executive committee of the Veterans Liaison Committee would be the incorporators.

Dr. Fithian moved that the Trustees authorize the setting up of a corporate body for the purposes described by Dr. Londrigan. Seconded and unanimously carried.

Dr. Schaaf reported that it had been determined that the best approach to the problem of examining veterans for disability and pension claims was the establishment of county-society sponsored examination units throughout the State. President Scammell had appointed a central committee to implement this procedure. Dr. Joseph F. Londrigan is Chairman of that Committee. Four other members, Dr. David B. Allman, Dr. William G. Herrman, Dr. Samuel J. Lloyd and Dr. E. LeRoy Wood,

were selected to represent the several districts in the Society, and to be responsible for the establishment of the program in the counties to which they were assigned. The Chairmen of the County Veteran Committees are also members of this State Committee.

The action of the Committee in selecting Dr. Yorke as Veterans Liaison Officer was confirmed by the Board of Trustees on motion made by Dr. Costello and unanimously approved.

DESIGNATION OF ACTING PRESIDENT

Dr. Schaaf reported that President Scammell was ill and would not be able to resume his duties as President for three or four months. Dr. Scammell has requested Dr. Schaaf to act for him during his illness. Dr. Schaaf asked for authority from the Trustees to carry out the request of Dr. Scammell.

Dr. Costello moved that Dr. Schaaf be empowered with the duties of President and be requested to perform them, as Acting President, until such time as Dr. Scammell was able to resume his duties. Seconded and unanimously carried.

INSURANCE COMMITTEE

Dr. Schaaf stated that an insurance company had cancelled the malpractice policy of one of the members of the Essex County Medical Society as soon as a claim was filed. Dr. Schaaf requested that the Trustees appoint a committee of three to review this case with the existing State Society Committee on Medical Defense and Insurance, the Essex County Medical Society and the insurance company.

Upon motion by Dr. Costello, seconded and unanimously carried, it was directed that an Insurance Committee from the Board of Trustees be appointed for the purposes requested by Dr. Schaaf.

Chairman Crowe appointed the following:

Dr. William F. Costello, Chairman
Dr. George W. Fithian
Dr. James F. Norton

SELECTION OF EXECUTIVE OFFICER

Dr. Schaaf stated that the Committee which had selected the Veterans Liaison Officer did not feel that it had the power to select an Executive Officer for the State Society. However, the Committee felt that the activities of the Society demanded the employment of a full time physician as Executive Officer, and also felt that it should be someone within the Society who is familiar with its work.

Dr. Fithian moved that the matter of an Executive Officer for the State Society be laid over until another meeting of the Board of Trustees. Seconded and carried.

N. J. DOCTOR'S ALMANAC

Dr. Barkhorn requested approval of the Trustees of the principle of publishing at the time of the Official List, an almanac, which would list information relative to hospital and cooperating agencies, and provide other material of general interest to the physicians of New Jersey.

Upon motion by Dr. Costello, seconded by Dr. Alexander and unanimously carried, Dr Barkhorn's request was approved.

ADJUSTMENT OF ASSESSMENT

The secretary read a communication from Dr. Chester I. Ulmer requesting consideration by the Trustees of reducing the per capita assessment for 1947 from $25, as recommended by the House of Delegates, to $20, in view of the fact that the Medical Society will not be obliged to pay the expenses of the Veterans Liaison Officer.

Opinion has been obtained from counsel, who stated that the Board of Trustees does not have the power to reduce the per capita assessment on members of the Society.

The secretary was accordingly authorized to notify Dr. Ulmer that only the House of Delegates had authority to take the requested action.

ANNUAL MEETING 1947

On motion of Dr. Stahl, the Trustees adopted the recommendation of the Reference Committee that the Haddon Hall in Atlantic City, if available, be the headquarters of the annual meeting in 1947. The Trustees selected April 22, 23 and 24 as dates for that meeting.

It was directed that the secretary write to President Scammell expressing the good wishes of the Trustees and their hopes for a prompt recovery.

ASSOCIATES AVAILABLE

If interested in establishing contact with any of these doctors, write to The Medical Society of New Jersey at 315 West State Street, Trenton 8, and indicate whether you are referring to notice 16, notice 17, etc.

UROLOGIST, age 36, veteran, five years training and experience in this specialty, desires assistantship or location for private practice. Refer to notice 25.

MATURE GENERAL PRACTITIONER now available as part-time associate for internist, dermatologist or obstetrician in northern New Jersey. Refer to notice 16.

PRACTITIONER EXPERIENCED IN TRAUMATIC SURGERY AND IN INDUSTRIAL MEDICINE, veteran, age 36, looking for association with doctor anywhere in New Jersey. Refer to notice 26.

WELL-TRAINED INTERNIST, Board-qualified, will be available in June for association with practitioner in any part of state. Refer to notice 17.

DERMATOLOGIST, BOARD DIPLOMATE, age 46, wants association with established dermatologist in any part of New Jersey. Refer to notice 18.

ROENTGENOLOGIST, BOARD-ELIGIBLE, age 39, formerly x-ray chief at army hospital, now available for association with group or with roentgenologist in northern New Jersey. Refer to notice 24.

WELL-TRAINED INTERNIST now available for association with a group. Refer to notice 19.

GENERAL PRACTITIONER with combat experience in traumatic surgery and army hospital experience in internal medicine, age 38, available for association in northern New Jersey. Refer to notice 20.

EXPERIENCED SURGEON, former Navy medical officer, age 42, capable of handling operative work in urology, orthopedics and gynecology, available for association with busy practitioner anywhere in New Jersey. Refer to notice 27.

GENERAL PRACTITIONER desires placement with physician in any specialty in northern New Jersey area. Age 33, veteran, fully licensed in this state. Refer to notice 28.

RADIOLOGIST, BOARD-ELIGIBLE, age 35, has had six years' experience in both diagnostic and therapeutic radiology, formerly chief of x-ray service in army hospital, now available for hospital, group or private office association anywhere in New Jersey. Refer to notice 29.

OBSTETRICIAN, GYNECOLOGIST, AMERICAN BOARD DIPLOMATE, age 33, licensed in both N. J. and N. Y., available for full-time or part-time association with established specialist or group, preferably in Northern New Jersey. Refer to notice 32.

SOUTHERN NEW JERSEY GENERAL PRACTITIONER, mature, long experience in medical practice, available as associate to internist, pediatrician, obstetrician or as associate to a medical group. Refer to notice 33.

HAVE YOU ORDERED YOUR TRISTATE DIRECTORY?

A limited number of copies of the new *Medical Directory of New York, New Jersey and Connecticut* are still available at 20 per cent discount off the regular price. This valuable desk book will be ready for release early in 1947 and as usual will list every physician and hospital in the three states with name, address, telephone, medical school, year of graduation, hospital connection and society membership for each doctor and complete staff rosters for each hospital.

It will be the first new edition since 1941. While the regular price is $7.50, our Executive Office has a small allotment available to it at a special price of $6. These will be set aside for the members who ask for a reservation and submit a check for $6 payable to The Medical Society of New Jersey. Send application and remittance to The Medical Society at 315 West State Street, Trenton 8. After our limited allotment is exhausted, copies may be purchased only at the full price of $7.50.

OFFICE SPACE AVAILABLE

A physician interested in any of the following announcements, will be furnished with further details by writing to The Medical Society of New Jersey, at 315 West State Street, Trenton 8. Indicate whether you are referring to notice 21, notice 22, etc.

SPACE AVAILABLE in North Newark area. Refer to notice 22.

SUBURBAN ESSEX COUNTY, office available to specialist or general practitioner. Refer to notice 31.

MEDICAL OFFICE BUILDING in central Newark. Space available as co-tenant with established internist. Refer to notice 21.

BEAUTIFULLY EQUIPPED OFFICE in central Newark area available to surgeon, dermatologist, otologist or gastro-enterologist willing to share space with established internist. Refer to notice 30.

ENROLLMENT RATIO IN VOLUNTARY HEALTH PLANS

By N. M. Scott, M.D.

The average practicing physician manifests little appreciation of or knowledge of the principles of medical economics as applied to voluntary medical service plans. Yet it is important that the practitioner have some knowledge of these problems since voluntary plans are the only approach yet evolved as an alternative to compulsory sickness insurance, and their success depends largely on the cooperation of the average physician. We need doctors in every county and in every community who understand our problems and appreciate the problems facing the medical profession and hospitals.

One primer-type lesson may be demonstrated by the experience of the Farm Security Administration Medical Care Plan. This plan, administered for the past five years by our Medical Service Administration for the benefit of low income farm families being rehabilitated by the federal government, provides payment for treatment ordinarily rendered by general practitioners in their offices or homes of patients. With adequate enrollment at annual subscription rates of $16. per individual and $20 to $24 per family, we have been able to maintain a fee schedule of $1.50 per office call, $2.50 per home call and set aside modest reserves.

An important factor in promoting the success of a voluntary plan is the ratio of enrollment maintained in the enrolled group. The safest proportion is 100 per cent of all eligible persons within the group. We then have a normal cross-section of health in the enrolled group. As this percentage decreases there develops an adverse cross-section of health, a higher claim rate and a decreased income per claim for physicians' fees.

During the past year the proportion of enrollment in this group has decreased. There are three reasons for this decrease — (1) the economic condition of some families has improved to the extent that they do not feel the need for this restricted program; (2) due to the general increase in professional fees, some physicians are not willing to render services to these people at the fees payable by the Plan; (3) there is a demand among this group for a complete program to include home, office, hospital care and the cost of hospitalization.

The increase in the sick rate during the past year, paralleling the decreased percentage of enrollment is demonstrated in the following statistics:

Period	No. of Families Enrolled	Sick Rate per 1000 per month
1945 January-March	320	57.3
1946 January-March	252	75.7

There has been a decrease in enrollment of 21 per cent and an increase in the sick rate of 18 per cent. This has been due to the development of an adverse cross section of health as a result of decreased percentage of enrollment. The income from the group is insufficient to meet the cost of the increased sick rate and has forced the use of reserves to maintain our fee schedule.

In the contract between Medical Service Administration and Farm Security Administration, it is the responsibility of Farm Security representatives to maintain a sufficient percentage of enrollment. These representatives believe they can obtain and maintain a sufficient enrollment if we offer this group a complete program, consisting of home and office care, medical and surgical care in hospital and the cost of hospitalization. Study is now being made, which we hope will lead to a satisfactory solution of this problem.

Rural medical care distribution is probably the most difficult problem facing the voluntary plan movement. The group under discussion provide the only opportunity yet offered to us for experimentation in this problem. For this reason we request the indulgence and participation of all physicians to assist us in evolving a solution of the problem of this deserving group.

PAYMENT FOR MEDICAL CARE OF VETERANS

The present status of vouchers presented to Veterans Administration by Medical Service Administration for the care rendered veterans between March 15th and May 13th is as follows:

We have been paid the following:

Date of Voucher	Amount
March 28, 1946	$ 709.35
April 15, 1946	8,389.40
April 30, 1946	13,758.95
May 15, 1946	29,550.20
	$52,407.90

The $29,550.20 represented by the May 15th voucher was received during the past month and distributed to the physicians who had rendered the services.

The following vouchers remain unpaid as of October 23, 1946. As soon as this money

Continues on page 469.

NUTRITION IN EVERYDAY PRACTICE*

S. William Kalb, M.D., Newark, N. J.
Chairman Nutrition Committee

FOLIC ACID

The following abstract of a radio interview between Milton Cross and Dr. Sebrell is published for the information of our readers. Dr. William H. Sebrell is medical director of the United States Public Health Service.

Dr. Sebrell: In 1939, Stokstad and Manning were studying the effect of various purified diets on chickens. They found that chicks required a dietary factor for growth which was not identical with any of the known vitamins. Without this factor in the diet chicks develop a severe form of anemia. Earlier work had shown that a factor was needed by monkeys, and other studies revealed that there was an unidentified factor in the Vitamin B Complex necessary for the growth of the microorganism *Lactobacillus casei*. The threads were drawn together when it was discovered that these factors were identical. The hitherto unknown vitamin required by monkeys . . . . for chicken growth . . . . and the factor necessary to bacterial growth were one and the same. The vitamin was first isolated in its pure form and very recently has been synthesized.

Mr. Cross: I see . . . . folic acid is actually a vitamin of the B Complex group.

Dr. Sebrell: That's right. The substance is so new that no generally accepted name has been selected. Various investigators prefer other names for folic acid. Here are just a few of the various terms used to identify this or very closely related factors . . . . Vitamin M, Factor U, Norite Eluate Factor, L. *casei* factor, and Vitamin Bc. However, for our purposes I think it will be best to refer to it as folic acid, with the clear understanding that as yet this term is not generally accepted.

Mr. Cross: What is the relationship between bacterial growth and the normal development of the individual?

Dr. Sebrell: It has been well established that the presence of certain bacteria in the intestinal tract is necessary for the synthesis of various vitamins. This has been used to advantage in the research projects that center about folic acid. Sulfa drugs have been fed to laboratory animals to inhibit the growth of bacteria. This has had the effect of shutting down the microorganism factories and withholding their vitamins from the body. The result was the development of severe blood dyscrasias. By this process we have been able to produce folic acid deficiencies in experimental animals, and to study the effect of the factor when it is supplied in synthetic form. Folic acid deficiencies result in leukopenia, granulocytopenia and anemia. The vitamin whether given by mouth or parenterally, seems to stimulate specifically the production of red blood cells, white blood cells and platelets.

Mr. Cross: Has the experimental work with folic acid progressed to the point where its clinical value in human disease can be evaluated properly?

Dr. Sebrell: We are only on the doorstep. The synthesis of this material has proved to be one of the most difficult technical problems in biochemistry. But it has been done. Just within the past few months, reports have begun to circulate relative to its therapeutic value in human medicine. These reports, while preliminary, show remarkable promise. A group of investigators recently reported on the anti-anemia properties of synthetic folic acid. Patients with macrocytic anemia in relapse exhibited a definitely positive response following the administration of this new material. The number of reticulocytes increased in the peripheral blood, and the red blood cell counts and hemoglobin content rose towards normal levels. Although the treatment was effective, it was probably no more effective than the results obtained by the administration of potent liver extract.

Mr. Cross: What other forms of anemia have been successfully treated by synthetic folic acid?

Dr. Sebrell: Patients with macrocytic anemia of sprue were greatly benefitted by this treatment. Less than a week after the first oral administration of synthetic folic acid, a spectacular increase in reticulocytes was noted. This was followed by a rise in the red blood cell count and in the hemoglobin. Tropical sprue treated with synthetic folic acid showed equal success. The patients quickly gained weight and strength, and their blood picture was remarkably improved. Pernicious anemia also has responded to folic acid treatment. There seems no doubt that folic acid is effective . . . . whether given oraly or parenterally . . . . for most of the macrocytic anemias. The hematologic response is rapid . . . . and it is

*Abstracted from a radio broadcast on April 14, 1946, sponsored by Lederle Laboratories and reprinted with permission of the sponsor.

coupled with an improvement in the absorption of water-soluble factors and the disappearance of glossitis and diarrhea.

MR. CROSS: Is there any danger in its use?

DR. SEBRELL: No. The pure synthetic folic acid possesses no toxicity in amounts many times that required for the normal therapeutic dose. However, its use parenterally calls for the observance of all the usual precautions required during parenteral therapy.

MR. CROSS: We have been concentrating on synthetic folic acid, Dr. Sebrell. In what specific foods is it possible to find this material?

DR. SEBRELL: Folic acid has been found in substantial amounts in liver, yeast, soy beans, bone marrow, and spinach. Generally speaking, it will probably be found widely distributed in nature. Folic acid cannot be substituted for an adequate diet in the treatment of macrocytic anemias. Such a diet should be high in both protein and vitamin content.

MR. CROSS: What is the relationship of folic acid to liver extract, from the therapeutic standpoint?

DR. SEBRELL: The picture is clarified, I think, when we remember that concentrated and refined liver extract contains only small amounts of folic acid. Anti-anemia effects may be produced in a number of ways . . . . two of which are represented by the administration of liver extract or folic acid. When an orally effective product for uncomplicated cases of sprue, macrocytic anemia of pregnancy and similar conditions is desired, then synthetic folic acid is the agent of choice. When patients are sensitive to liver, folic acid is the best treatment.

MR. CROSS: I understand that it is necessary to keep the patient supplied with liver extract even after the clinical symptoms of disease had disappeared. Is this procedure necessary when folic acid is used?

DR. SEBRELL: Yes. Maintenance doses are required even after the clinical symptoms of the condition subside. This appears to be less than the dose required for effective treatment. The patient should be kept under close supervision and the maintenance dose adjusted if relapse appears imminent.

MR. CROSS: Has folic acid been found valuable in any but the macrocytic enemias?

DR. SEBRELL: The substance is so new that there has been little time in which to test its clinical action. On the basis of preliminary reports, folic acid is of no value in the aplastic anemias. There is some indication, however, that it does produce an increase in leukocytes in patients who have developed leukopenia as a result of deep x-ray therapy. But here, again, there is not enough fact to go on. What little we know is merely a guidepost for future research.

SUMMARY

It has been just within the past few months that folic acid has been demonstrated to be of real value in human medicine. Patients with various forms of macrocytic anemia have been successfully treated with synthetic folic acid. This newest member of the Vitamin B family may well prove to be of major importance in the treatment of blood dyscrasias. But we are just touching the field . . . . in time we must get our hands full upon the subject and discover the reasons behind the physiologic action of folic acid, and its real place in medicine.

VOLUNTARY HEALTH PLANS (Continued)

is received it will be distributed to the individual physician who rendered the services.

Date of Voucher	Amount
May 30, 1946	$ 9,426.25
June 15, 1946	5,573.65
August 15, 1946	6,628.45
September 15, 1946	1,837.35
	$23,465.70

MEDICAL-SURGICAL PLAN OF NEW JERSEY

The enrollment as of September 30, 1946, was 77,601 persons. The financial experience for the 9-month period ending September 30th was as follows:

Earned Subscription Income	$369,133.81
Claims Incurred	261,456.60
Operating Expenses	61,684.38

The experience for the month of September was:

Earned Subscription Income	$ 50,814.26
Claims Incurred	29,983.50
Operating Expenses	7,935.40

GONOCOCCUS CULTURE STATIONS IN NEW JERSEY

This is a revised list (October, 1946) of stations cooperating with the State Health Department in providing gonococcus culture facilities. Specimen tubes may be obtained at any of these stations and must be returned to the incubator at the station *within three hours* after the slant has been streaked. To obtain satisfactory results, the instructions accompanying each tube must be meticulously followed.

ALLENTOWN—Farmers Hospital.
ASBURY PARK—Bureau of Health.
ATLANTIC CITY—Atlantic City or Municipal Hospitals; Hunt Laboratory (805 Atlantic Avenue) or Kurland Pharmacy (118 Dewey Place).
BAYONNE—Bayonne Hospital.
BELLEVILLE—Department of Health (Town Hall).
BLOOMFIELD—Health Department.
BOUND BROOK—Bound Brook Hospital.
BRIDGETON—Bridgeton Hospital.
CAMDEN—Cooper or West Jersey Homeopathic Hospital.
CAPE MAY COURT HOUSE—The Court House Building.
CRANFORD—Hampton Laboratory (321 Casino Avenue).
DOVER—The Dover General Hospital; also at the District Health Office (16 West Blackwell St.)
EAST ORANGE—General Hospital; also at the City Health Department.
ELIZABETH—St. Elizabeth's Hospital; the Biochemical Laboratory (1137 East Jersey Street) or the City Health Department.
ENGLEWOOD—Englewood Hospital.
FAIR LAWN—Fair Lawn Clinical Laboratory (75 Midland Avenue).
FRANKLIN—Franklin Hospital.
FREEHOLD—Freehold Health Center (Lafayette Place).
HACKENSACK—District Health Office (Room 207 Administration Building).
HOBOKEN—St. Mary's Hospital.
IRVINGTON—Health Department.
JERSEY CITY—Christ Hospital; Hudson County Board of Health Laboratory; the Medical Center, Physicians and Surgeons Clinical Laboratory (591 Summit Ave.) and St. Francis Hospital.
KEARNY—West Hudson Hospital.
KEYPORT—Health Department.
LAKEWOOD—Paul Kimball Hospital.
LINDEN—Health Department, City Hall.
LONG BRANCH—Board of Health (City Hall) and also the Monmouth Memorial Hospital.
MAY'S LANDING—District Regional Health Office.
MILLVILLE—Millville Hospital.
MONTCLAIR—Health Department (65 Chestnut St); the Mountainside Hospital and the Montclair Community Hospital.
MORRISTOWN—All Souls' Hospital and the Morristown Memorial Hospital.
MOUNT HOLLY—Burlington County Hospital.
NEPTUNE—Fitkin Memorial Hospital; also the Township Board of Health.
NEWARK—Any of the following hospitals: American Legion, Beth Israel, Babies, City, Columbus, Community, Lutheran Memorial, Presbyterian, St. Barnabas, St. James or St. Michaels; also at the Clinical Laboratory (31 Lincoln Park).
NEW BRUNSWICK—Middlesex General or St. Peter's Hospital.
NEW MONMOUTH—Middletown Health Center.
NEWTON—Memorial Hospital.
NORTH ARLINGTON—Health Department.
NUTLEY—Health Department.
OCEAN CITY—Friel Laboratory (332 Asbury Avenue).
ORANGE—Memorial Hospital or St. Mary's Hospital.
PASSAIC—General Hospital, St. Mary's Hospital, Beth Israel Hospital, Laboratory Service (199 Monroe St.) or Clinical Laboratory (20 Grove Street).
PERTH AMBOY—General Hospital; or the Laboratory at 138 Market St.
PHILLIPSBURG—Warren Hospital.
PRINCETON—Health Department or Princeton Hospital.
RAHWAY—Rahway Hospital.
RED BANK—Riverview Hospital; or either of the Clinical Laboratories at 157 Broad Street (room 28) or 71 East Front Street.
RIVERSIDE—Zurbrugg Hospital.
ROSELLE—Board of Health.
SALEM—County Memorial Hospital.
SECAUCUS—Hudson County Hospital for Contagious Diseases.
SOMERS POINT—Shore Memorial Hospital.
SOMERVILLE—Somerset Hospital.
SUMMIT—Overlook Hospital, the Summit Medical Group (129 Summit Ave.) or the Health Department (71 Summit Ave.).
SUSSEX—Alexander Linn Hospital.
TOMS RIVER—Ocean County Health Department.
TRENTON—Mercer, McKinley or St. Francis Hospitals.
UNION CITY—Board of Health (Town Hall) or Diagnostic Laboratory at 408 Thirty-Sixth Street.
VINELAND—Newcomb Hospital.
WEEHAWKEN—North Hudson Hospital.
WESTFIELD—The Board of Health; also the Clinipath Laboratories in the Rialto Building.
WEST NEW YORK—General Research Laboratory (444 West 60th St.).
WOODBURY—Underwood Hospital.

If your community is not included in this list, use the nearest station. If culture facilities are not readily available, discuss the matter with the local Health Officer or write to the State Health Department (State House, Trenton 7). If considering setting up a local station, remember that a refrigerator and an incubator must be accessible there at all times.

SIMPLIFIED METRIC-APOTHECARY CONVERSION TABLE

The following conversion table was prepared jointly by the U. S. Pharmacopeia, the National Formulary and the NNR editors for the American Medical Association. It also enjoys the approval of the Federal Food and Drug Administration.

Recent action by the American Medical Association in adopting the metric system only for its publications, and general recognition of the desirability and wisdom of such a policy in all of the related fields of medicine and pharmacy, led to the preparation of this table as a means of placing primary emphasis upon metric rather than upon apothecary doses and simplifying the former. Heretofore, metric doses were usually based upon a primary apothecary dose and were relatively accurate equivalents. For example, 32 milligrams and 325 milligrams were considered as dose equivalents for ½ grain and 5 grains respectively. However, when one thinks primarily in terms of the metric system the logical doses in the above cases become 30 mg. and 300 mg., both of which will be just as efficient therapeutically as were their counterparts, 32 mg. and 325 mg. Actually the metric dose quantities now accepted are those which have been used in the Pharmacopoeia since 1916 when the U.S.P. IX made its appearance.

LIQUID MEASURE

Metric	Approximate Apothecary Equivalents
1000 cc.	1 quart
750 cc.	1½ pints
500 cc.	1 pint
250 cc.	8 fluidounces
200 cc.	7 fluidounces
100 cc.	3½ fluidounces
50 cc.	1¾ fluidounces
30 cc.	1 fluidounce
15 cc.	4 fluidrachms
10 cc.	2½ fluidrachms
8 cc.	2 fluidrachms
5 cc.	1¼ fluidrachms
4 cc.	1 fluidrachm
3 cc.	45 minims
2 cc.	30 minims
1 cc.	15 minims
0.75 cc.	12 minims
0.6 cc.	10 minims
0.5 cc.	8 minims
0.3 cc.	5 minims
0.25 cc.	4 minims
0.2 cc.	3 minims
0.1 cc.	1½ minims
0.06 cc.	1 minim
0.05 cc.	¾ minim
0.03 cc.	½ minim

WEIGHT

Metric	Approximate Apothecary Equivalents
30 Gm.	1 ounce
15 Gm.	4 drachms
10 Gm.	2½ drachms
7.5 Gm.	2 drachms
6 Gm.	90 grains
5 Gm.	75 grains
4 Gm.	60 grains
3 Gm.	45 grains
2 Gm.	30 grains
1.5 Gm.	22 grains
1 Gm.	15 grains
0.75 Gm.	12 grains
0.6 Gm.	10 grains
0.5 Gm.	7½ grains
0.4 Gm.	6 grains
0.3 Gm.	5 grains
0.25 Gm.	4 grains
0.2 Gm.	3 grains
0.15 Gm.	2½ grains
0.12 Gm.	2 grains
0.1 Gm.	1½ grains
75 mg.	1¼ grains
60 mg.	1 grain
50 mg.	¾ grain
40 mg.	2/3 grain
30 mg.	½ grain
25 mg.	⅜ grain
20 mg.	⅓ grain
15 mg.	¼ grain
12 mg.	1/5 grain
10 mg.	1/6 grain
8 mg.	⅛ grain
6 mg.	1/10 grain
5 mg.	1/12 grain
4 mg.	1/15 grain
3 mg.	1/20 grain
2 mg.	1/30 grain
1.5 mg.	1/40 grain
1.2 mg.	1/50 grain
1 mg.	1/60 grain
0.8 mg.	1/80 grain
0.6 mg.	1/100 grain
0.5 mg.	1/120 grain
0.4 mg.	1/150 grain
0.3 mg.	1/200 grain
0.25 mg.	1/250 grain
0.2 mg.	1/300 grain
0.15 mg.	1/400 grain
0.12 mg.	1/500 grain
0.1 mg.	1/600 grain

Note—A cubic centimeter is the approximate equivalent of a milliliter.

Copies of this table, printed on cards for doctor's desk use are available on request directed to Committee of Revision, U. S. Pharmacopeia, 4738 Kingsessing Avenue, Philadelphia 43, Penna. Ask for the new *Table of Metric Doses with Approximate Apothecary Equivalents.*

OBITUARIES

DR. WILLIAM GOLDSTEIN

Dr. William Goldstein of Kearny died unexpectedly in Newark at the age of 52 on October 5, following a cerebral hemorrhage. A native of Newark, he was graduated from the Bellevue Medical College in 1917 and immediately entered the Army of the United States, serving as a captain in the medical corps until the armistice in 1918. He then interned at St. Michael's Hospital in Newark and subsequently opened an office in Kearny. Always interested in surgery, Dr. Goldstein devoted increasing amounts of his time to that specialty and eventually became chief of staff at the West Hudson Hospital in Kearny and an associate surgeon at Beth Israel Hospital in Newark. He was active in the affairs of the American College of Surgeons and was a member of the Essex County Medical Society.

DR. EUGENE A. MEACHAM

Dr. Eugene A. Meacham died at his home in South Amboy on September 28, 1946, at the age of 73. Ever since the chartering of South Amboy as a city, Dr. Meacham had served as city physician, and he was considered the best known and best loved resident of that municipality. He won statewide fame in 1918 for his heroic role in treating victims of the Morgan explosion disaster that year and for his unremitting and successful labors in bringing under control the influenza epidemic that threatened the county immediately after the explosion. Dr. Meacham was graduated from the medical school of New York University in 1898. He was chairman of the board of governors of the Roosevelt Hospital in Metuchen, and a member of the staff of the Perth Amboy General Hospital, but his most intimate identification was with the South Amboy Memorial Hospital which for many years he served as chief of staff.

SOCIAL SECURITY POINTERS FOR ELDERLY WORKERS

To make sure that workers 65 and over get all the retirement benefits that may be due them under the old-age and survivors insurance program, physicians should advise them to get in touch with the nearest office of the Social Security Board when they reach 65, regardless of whether they intend to retire or to remain workers.

An elderly worker is especially likely to have an illness which would keep him out of the labor market for several months. Such a worker should know that an application for retirement benefits could be filed immediately with a Social Security Board office; thus his monthly benefits would start coming to him promptly. They would come to him during his months of illness. Monthly benefits do not come automatically. *A claim for benefits must be filed before payment can be made.* Retirement benefits are not retroactive and once lost, no part of the loss can be recovered.

An aged worker may lose his job or be unemployed for longer or shorter periods of time. He may have to shift from time to time into work not covered by the provisions of the old-age and survivors insurance program, where wages do not count toward old-age and survivors insurance benefits.

These conditions would tend to lower a worker's average wage on which his retirement is figured. Therefore, it is wise to visit a Social Security Board field office to be advised as to how and when to file for monthly benefits. If he is fully insured, it may be better for a worker to file a claim for benefits as soon as he reaches 65.

It is generally to the worker's advantage to file a claim if his wages begin to fall, if he begins losing time on covered jobs, or if he works in a job that does not come under the provisions of the old-age and survivors insurance program, such as farming, domestic work in a private home or self-employment.

Field offices located in New Jersey are found in Atlantic City, Bridgeton, Camden, Elizabeth, Jersey City, Newark, Passaic, Paterson, Perth Amboy and Trenton. Addresses will be found in the telephone book or may be obtained by inquiry at the nearest post office.

—Information furnished by Social Security Board, Trenton 9, N. J.

A. M. A. SCIENTIFIC EXHIBIT

At the Centennial Session of the American Medical Association in Atlantic City, June 9 to 13, 1947, the Scientific Exhibit will include both the history of medicine during the past century and the latest developments of medical science.

NEW JERSEY STATE DEPARTMENT OF HEALTH

PUBLIC HEALTH NEWS FOR THE PHYSICIAN

State of New Jersey
DEPARTMENT OF HEALTH
J. LYNN MAHAFFEY, M.D., DIRECTOR
TRENTON

October 21, 1946

To The Physicians of New Jersey:

Through the courtesy of the Publication Committee of the Medical Society of New Jersey, I am privileged to inaugurate with this issue of the Journal, a new regular page of Public Health News of interest to the physicians of New Jersey. It is the intention of the State Department of Health to provide material for this regular feature which we trust will be of both interest and value to the general practitioner and which will supplement the official notices and reports that are sent to you by mail.

Suggestions as to the type of material which would be of greatest value are solicited since it is our intention to make this feature as worthwhile as can be done.

Very truly yours,
J. Lynn Mahaffey
J. Lynn Mahaffey, M.D.
Director of Health

Blood plasma supplied by the American Red Cross from the excess above the needs of the Armed Forces has been allotted to the various states for distribution through the State Health Departments. The allotment to New Jersey has been placed in distributing stations where it is available to physicians for their use. These stations, 143 in number, include hospitals, state police stations, and the offices of local boards of health in some municipalities. A list of stations has been mailed to all physicians and a copy may be obtained by writing to the Department.

Physicians obtaining plasma are requested to notify the State Health Department of the name of the person on whom the plasma is used and the condition for which it is used. Addressed postal card forms for the convenience of physicians in making such reports are available at each distributing station.

PENICILLIN TREATMENT OF GONORRHEA

The Division of Venereal Disease Control of the State Department of Health has been supplying penicillin to physicians and clinics for the treatment of gonorrhea, with the recommendation that 200,000 units be divided into three doses and given at two-hour intervals. By this method, treatment is completed in four hours. Further experimentation indicates that the time period may be reduced to two hours. The initial injection may be 100,000 units, with the other 100,000 units given two hours later, or 50,000 units may be used for the first dose, another 50,000 units given one hour later, and 100,000 units at the end of the second hour.

POB (penicillin in oil and beeswax—Romansky formula) is now being made available by the pharmaceutical houses in single dose cartridges. Probably this preparation will be preferred to the aqueous solution of penicillin by most physicians for the treatment of gonorrhea. Treatment consists of 300,000 units, given in a single injection. The time thus saved for both patient and physician is an important factor.

The possibility of curing gonorrhea in a single injection makes rapid contact tracing imperative. Many cases considered treatment failures are, in fact, re-infections. This is particularly likely to happen if the sex partner is not treated promptly. The services of public health nurses (trained and experienced in interviewing venereal disease patients and contacts) are available to physicians. "Shoe leather" epidemiology was never more important than today when cure and reinfection may occur within a few days.

NEW APPOINTMENTS

Proceeding with its reorganization and expansion program which has been implemented since the end of the war, the New Jersey State Board of Health at its regular meeting on October 8 established a Division of Cancer Control, appointed a new Director of the Bureau of Preventable Diseases, and appointed a staff nutritionist.

Dr. Raymond V. Brokaw was appointed Chief of the newly organized Division of Cancer Control and Mrs. S. M. Errickson was appointed Nurse Consultant, in the Division. Dr. Brokaw was Field Representative and Executive Secretary of the American Cancer Society and was formerly Chief, Division of Cancer Control, Illinois State Department of Health. An advisory council on cancer is to be named to work with the State Board of Health.

Dr. Roscoe P. Kandle was appointed Director, Bureau of Preventable Diseases replacing Dr. L. S. Snegireff, resigned. He formerly served as District Health Officer for the New Jersey State Department of Health and held a similar position in New Mexico. He served also as Director, Division of Local Health Service, Louisiana State Department of Health and was Associate Field Director, American Public Health Association, prior to his new appointment.

Miss Elizabeth Ann Porter was appointed Staff Nutritionist, in the Bureau of Preventable Diseases. She comes to New Jersey with considerable experience in nutrition education and served for seven years as a Staff Nutritionist in the Pennsylvania State Department of Health.

At the same meeting the State Board instructed its Medical Care Committee to restudy the distribution of free biologicals to physicians as a result of a request from the Newark City Health Department for the distribution of free influenza vaccines by the Department.

BOOK REVIEWS

Howell's Textbook of Physiology. Edited by John F. Fulton, M.D. Fifteenth Edition, illustrated. Philadelphia and London. W. B. Saunders Company. 1946. $8.00.

This is not particularly a book of pointed clinical application nor is very much reference made to abnormal physiology except in a brief way. In this respect it may be slightly disappointing to the clinician. Furthermore, the author's hobby or fundamental concept, if you will, is evident in the first section of the book, which devotes 176 pages to muscle nerve physiology. There is a fine regard for the historical development in some detail on this subject. Other well known books give more space to the physiology of metabolism or the circulatory system. Let it not be construed, however, that these subjects are elided, but rather that they are equally well if somewhat more briefly covered.

The two most outstanding features of this book are its unusual readability and its up-to-date reporting of the newest concepts of the present day research. In this sense it is almost a new book rather than a new edition. From this angle in particular it bears careful perusal by the medical man who wishes to remain well and easily informed on this all important basic subject.

The Management of Fractures, Dislocations, and Sprains. By John Albert Key, B.S., M.D., and H. Earle Conwell, M.D., F.A.C.S. St. Louis. The C. V. Mosby Company, 1946. $12.50.

In this extensive and voluminous book containing 1298 pages with 1316 figures we have an excellent reference work. The authors have brought the book up to date from experience with the large number of injuries resulting as a result of the recent world war.

This edition is divided into two parts. Part I deals with principles and general aspects of the subject such as fracture equipment, repair of fractures, physical therapy, complications of fractures, pathologic fractures, compound fractures and war wounds. The chapters on the Workmen's Compensation Law and the medico-legal aspects of fracture cases are especially good.

Part II deals with specific trauma from fractures of the skull to injuries of the foot. In the next edition the authors should give more space to the pathology found in cases of recurrent dislocation of the shoulder and include the Bankart operation for this condition.

This book is recommended as a reference volume for the student, general practitioner and specialist.

Psychotherapy in General Medicine. By Geddes Smith. Commonwealth Fund, New York. 1946. Pamphlet, 38 pages. $0.25.

In April, 1946, twenty-five general practitioners attended a two-weeks' course in psychotherapy at the University of Minnesota. This pamphlet is a report of the result of an experiment in trying to teach general practitioners how to use in their own offices the kind of medicine which neurotic patients so desperately need. It is an alive, warmly written narrative which uses homely, down-to-earth examples of the technics used both in teaching the doctors and treating the patients. As one of the student-physicians said of the course, "they take the hot air out of psychiatry". The same may be said of this booklet. Indeed, this brochure is itself an orientation to the psychotherapeutic method as well as a record of a clinical and pedagogic experiment. It is a useful source book to any one planning to give or take a course in psychotherapy or psychosomatics and provides a well-spent hour for any psychiatrist, pediatrician or general practitioner.

VETERANS CARE PLAN

By Edward T. Yorke, M.D., Liaison Officer

VA Central Office in Washington has notified subsidiary offices that veterans will now be hospitalized in government hospitals. Only in certain emergencies will veterans be permitted to undergo care in local hospitals at VA expense.

VA FEES LIMITED TO $6000 PER YEAR

Physicians appointed on a fee basis are not to earn more than $6000 a year. So says VA circular 233, dated September 24, 1946.*

The Regional Office in Newark (serving the entire state) has interpreted the circular to mean that it cannot pay any more fees to a physician once his account reaches $6000.

VA in Newark has notified the Philadelphia Branch that controls will be set up for the fiscal year 1947, which began July 1, 1946, to determine the earnings of physicians on a fee basis.

An incomplete list of physicians has been compiled, showing, for many, a probable earning capacity in excess of $6000 a year based on the months of June, July and August.

The origin of this decision appears to be a ruling by the Administrator of VA upon the recommendation of the Chief Medical Director. The law itself does not appear to set any limit to earnings of physicians.

In the county pension examination program, VA will not pay individual physicians.

HEAVY PENSION EXAMINATION LOAD EXPECTED

Dr. Fagley, Chief Medical Officer, of VA in Newark, has planned to submit 6,000 veterans pension cases a month to the examining units sponsored by the county societies. Accurate figures are unobtainable but it is estimated that the backlog of cases is close to 130,000. Approval has been given to Newark by higher authority to employ examining units in hospitals to reduce this backlog.

Having made a careful presentation of the program to the county societies, the committee (headed by Dr. Joseph F. Londrigan of Hoboken and consisting of Dr. E. L. Wood of Newark, Dr. S. Lloyd of Trenton, Dr. W. Herrman of Asbury Park and Dr. D. Allman of Atlantic City) have obtained an excellent response, not only from the physicians but also from the hospitals in which the examining units will operate.

EXAMINATION REPORTS MUST BE SUITABLE

VA reserves the right to reject reports of physical examination that are not fit for rating purposes.

In the operation of an examining unit where several physicians are making examinations, the development of local responsibility to a special degree is essential in determining that the reports are suitable for rating.

The VA *Manual for Medical Examiners* may appear frightening unless one understands that it is a ready reference guide which does not have to be read through. A variety of defects is spread through the booklet. Reference to only those pertinent to the veteran's claim is necessary before an examination is made so that the physician will have a clear conception of the requirements of the Rating Board which makes a final decision on the claim.

A manual should be available at the examining unit for the use of the physicians.

There should be an understanding locally that the Liaison Officer cannot cope with a situation involving several thousand examination reports a month if a high proportion are unacceptable for rating purposes.

A mimeographed *Procedure for Examinations* for VA by examining units has been mailed to the chairman of the County Veterans Liaison Committees.

DISCUSSION OF CLAIM WITH THE VETERAN

An examining physician should not discuss with a veteran the features of his examination relative to his claim nor the degree of disability he may present.

A physician who examined a veteran in initiating his claim is not permitted to make a subsequent examination for the Rating Board.

* It is understood that a review of this circular will be forthcoming, liberalizing yearly earnings in certain cases—E.Y.

COUNTY SOCIETY REPORTS

ATLANTIC COUNTY

A. G. Merendino, M.D., Reporter

The regular monthly meeting of the *Medical Society of Atlantic County* was held at the Traymore Hotel on September 13th, at 9 p. m. Theodore R. Fetter, M.D., Associate Attending Urologist at Jefferson Medical College and Hospital, was the guest speaker. His subject was: *The Pathogenesis of Chronic Urinary Obstruction.* Dr. Fetter discussed the more common causes of obstruction with particular reference to the pathology in the female generative organs. In addition to chronic infection of the urinary tract, the end result may readily be a hydronephrosis or pyonephrosis, atrophy or a contracted kidney. The life of the patient is endangered by suppurative pyelonephritis. Particularly insidious in its onset and progression, is adnexal disease in the female, which eventually causes bilateral ureteral block and impairment of renal capacity. Acute, complete, unilateral blockage causes no serious changes in the pelvis or kidney other than a mild inflammation of the pelvic mucosa and hemorrhagic appearance of the parenchyma, and prompt cessation of function. In the presence of infection there will be an infected hydronephrosis and suppuration of the parenchyma and finally destruction of the organ. Prompt unblocking of the ureter will prevent progressive infectious changes, and function of the kidney is resumed. Chronic ureteral block induces infection and renal function becomes progressively impaired. Dr. Fetter stressed that the recognition of the dangers of chronic urinary obstruction should be obvious to all of us; that many cases resolve themselves into acute surgical emergencies. He went on to say, "Many patients die an untimely death as a result of lack of appreciation of the real significance of urinary obstruction. If you are of the opinion that a patient must have several episodes of acute retention of urine because of an enlarged prostate before advising treatment, your results will not be as happy as those of your colleague who advises prompt attention when symptoms of bladder neck obstruction arise." Emphasis was placed upon complete urologic survey in children suffering disturbances of urination and pyuria.

The paper was discussed by Dr. Shivers, who added to the subject with lantern slide illustrations. Other members voiced their appreciation for the excellent presentation.

BERGEN COUNTY

H. E. Reinhold, M.D., Reporter

Regular meeting of the *Bergen County Medical Society,* held at Bergen Pines Hospital, Oradell, N. J., on the evening of September 10, 1946, was called to order by the president, Dr. Albert W. Cloud, at 9:20 p. m.

Minutes of the meeting of May 14 were dispensed with and are to be read at the next Annual Meeting.

On recommendation of the Membership Committee, the following applicants were elected to full membership: Dr. Louise Lowe of Hackensack, Dr. Grace C. Hardy of Tenafly, Dr. E. J. Burokus of Maywood, Dr. Doris E. Rappaport of West Englewood. Dr. Monroe E. Neuman of Hackensack, Dr. Vinicio G. Liva of Lyndhurst, Dr. Peter G. Hunziker of West Englewood, Dr. Roy Pollack of Cliffside Park, Dr. Thomas J. Sperber of West Englewood, Dr. John F. Fiery of Bergenfield were elected to associate membership.

The speaker of the evening, Dr. William Thalhimer, president of the Queens County Blood Plasma Bank, was introduced by Dr. George Heller. His subject was *Present Day Use of Blood and Plasma.*

Dr. Thalhimer gave an interesting resume of his experience in the field of blood transfusion. He dated his experience from his early days of practice at Mt. Sinai Hospital in 1915, and traced the progress of transfusion from the old direct method to the present date when the indirect method is the method of almost universal choice.

The meeting adjourned at 11:15 p. m.

CAMDEN COUNTY

J. C. Lovett, M.D., Reporter

The regular monthly meeting of the *Camden County Medical Society* was held on October 1, 1946, at the Camden City Dispensary with the president, Dr. Henry Decker, in the chair.

Dr. Helen Schrack, the historian, reported on the progress of compiling the names and data of all the members of the Camden County Medical Society in the past one-hundred years. It was voted by the Society that it should not be published this year.

Dr. R. S. Wright, treasurer, gave his report for the year. He stated there is a reduction of two dollars in dues this year as there was an overcharge last year.

Dr. T. B. Lee, Chairman of the Centennial Committee, told of the arrangements being made for the celebration. It was approved by the Society that the centennial meeting be held at the Walt Whitman Hotel on November 7, 1946, instead of November 2, 1946, and that the committee should go ahead with the plans.

Dr. H. Wesley Jack, Chairman of the Welfare Committee, reported that the work is continuing and a great deal is being accomplished.

The following were elected to membership: Dr. Ralph D. Cavalli, Dr. J. S. Klinger, Dr. John J. Jablonski, Dr. Nicholas Musulin, Dr. Leopold Reiner and Dr. Joseph Skyer, all of Camden, and Dr. Earl B. Keller of Oaklyn.

Applications were received from eight physicians for membership. These will be acted upon at the

next meeting.

It was approved by the Society that there should be a remission of dues for all members in service and those discharged after October 1, 1946.

A resolution was presented for the incorporation of the Camden County Medical Society. The purpose of the corporation would be to confederate the physicians into one organization and to promote the purposes of the medical profession. This was approved by the Society.

The consideration of organizing an examining center in Camden for the Veterans Administration for the diagnosis of service-connected injuries and diseases was taken up for discussion by DR. WILLIAM T. SNAGG, Chairman of the Camden Liaison Committee. The organization of this center is being urged by The Medical Society of New Jersey and it is to be for pension claims only. Dr. Snagg explained the Veterans Administration's plans and also that the Administration demands a contract with the Society. SAMUEL J. LLOYD, M.D., representative of the State Society, further explained the plan and answered questions concerning it. General discussion followed. DR. REUBEN SHARP moved that this be referred to the Executive Committee for further consideration, investigation and plans to be worked out for presentation of it to the Society.

CAPE MAY COUNTY

C. W. Way, M.D., Reporter

A meeting of the *Cape May County Medical Society* was held October 1 at Fred's Restaurant, Cape May Court House, N. J. The meeting was called to order by the president, J. S. D. EISENHOWER, JR. Drs. Robert A. Cornwell of Ocean City and Samuel Mazzotta of Wildwood Crest were elected to membership.

The proposition for the examination of veteran patients was explained by DR. A. C. CROWE, Ocean City, Chairman of the Board of Trustees of The Medical Society of New Jersey. There are now about 175,000 veterans to be taken care of in the state. The new plan is to given an examination of the specific part of the body involved as requested by the Veterans Administration. It has been advised by the state that a social worker should be the administrator of the clinic under the jurisdiction of the County Medical Society and that lay representatives of the Veterans Administration should work in the clinics. This means a center should be established in Cape May County. It was also brought out that in the working out of the program it will be necessary to keep files and records of the veterans' examinations. It was recommended that a special committee study this timely and important matter.

The Cape May County Medical Society has successfully set up a disability insurance program which is very attractive for its coverage as well as its low cost. All members of the armed forces returning to active practice are privileged to take out this policy on a non-selective and non-cancellable basis regardless of physical disability, past or present. This must be purchased within sixty days of return to civilian practice. Interested physicians should call the secretary, Dr. C. W. Way, Sea Isle City, for further information and rates.

After a long and interesting discussion by nearly every member present of the proposed Burdette Tomlin Memorial Hospital, it was decided that each doctor would give what he desired and that a lump sum should not be given by the Cape May County Medical Society. The hospital has been planned in the form of a modified "T" for a maximum of sunlight, fresh air and effective service. When completed it will have accommodations for 68 patients while the nurseries can house sixteen newborn infants. A complete out-patient department affording ambulatory diagnosis and treatment for patients from all parts of Cape May County will be a feature of the ground floor.

Two wings of the second floor will be devoted to maternity and surgical patients. Cost of construction and equipment will be $400,000. Responsibility for staffing this hospital rests squarely on every member of the Cape May County Medical Society. Ground has already been purchased. It is a quarter mile from the center of Cape May Court House, at the corner of the Stone Harbor Boulevard. Only three miles from the Atlantic Ocean, it is at a central point which can be reached conveniently from all communities in Cape May County.

A splendid midnight supper was served to the largest attendance in four years.

CUMBERLAND COUNTY

Norman W. Henry, M.D., Reporter

The regular meeting of the *Cumberland County Medical Society* was held June 11, 1946, at the Owens Illinois Glass Company at Bridgeton, N. J. DR. ALBERT KUMP, president, was in charge. Twenty-eight members were present.

A tour of the plant was made. We saw quantities of glass, bottles and jars in various stages of manufacture.

A motion picture entitled *Industrial Medicine* was presented and enjoyed by everyone.

There was no new business to be discussed and the meeting adjourned following a dinner held in the club room of the plant.

ESSEX COUNTY

Felix J. Di Fino, M.D., Reporter

SENATOR H. ALEXANDER SMITH was the principal speaker at the October meeting of the *Essex County Medical Society* held at the Academy of Medicine, in Newark, October 10, 1946. DR. T. W. HARVEY presided. Senator Smith gave a very enlightening and interesting talk on the merits of the Taft-Smith-Ball Health Bill (S 2143) which calls for federal grants to be given to the state for provision of medical care for the people in the lower income brackets. The next speaker was Congressman ROBERT W. KEAN who heartily endorsed Senator Smith's health bill. After some discussion, motion was made that the Essex County Medical Society endorse the Taft-Smith-Ball Bill in principle and

give its approval to the efforts of Senator H. Alexander Smith who represents us in Congress. This motion was carried.

The following applicants were elected to membership:

For Reinstatement:

Kearney, J. F., Maplewood
Thum, Kurt, West Orange

ForTransfer—Active:

Anderson, W. E. Newark
Chiaramida, Joseph, Verona
Dorris, Earl D., Cedar Grove
Flicker, David J., Newark
Irwin, Francis T., Caldwell
Pollock, Samuel D., Maplewood
Rattene, Edward, Newark
Reich, Emma, Verona
Scheiber, Geza, Arlington
Smith, Jarvis M., Montclair

For Active:

Booken, Gerald J., Newark
De Marco, Luciano, Harrison
Keats, Sidney, Orange
Onorato, Vincenzo R., Newark
Weisbrod, Lawrence H., Newark

For Associate:

Alterbaum, George, Caldwell
August, Jack, East Orange
Bensel, Arlington, East Orange
Comando, Edward N., Newark
Evans, John R., Jr., Maplewood
Finkelstein, Aaron, Newark
Gianquinto, Peter J., Newark
Gras, Alfred E., Newark
Hanfling, Seymour L., East Orange
Hermann, John H., Jr., Orange
Hertzberg, Irving, Paterson
Holder, Lester, East Orange
Judge, T. V., Newark
Kawalek, Roman, East Orange
Kenny, James J., Orange
La Caille, Rupert A., Newark
Mason, John T., Cedar Grove
Murray, Edward F., Newark
Pilpel, Michael, Newark
Rath, Maurice, East Orange
Ritota, Michael C., Newark
Rubin, Sidney, Newark
Schwarzfeld, Howard K., Newark
Sharlin, Herbert S., Newark
Smith, Alan L., East Orange
Van Amberg, Robert J., East Orange
Waldron, John F., South Orange
Wannemacher, Paul H., West Orange
Weiss, Fred, Newark

GLOUCESTER COUNTY

D. R. Brewer Jr., M.D., Reporter

The Owens Illinois Glass Works of Glassboro, was host to the *Gloucester County Medical Society* at its regular meeting on September 19, 1946, with Dr. Louis Collins, presiding.

Dr. J. Harris Underwood, chairman of the Cancer Control Committee announced the plans for a cancer clinic to be held regularly in Woodbury. This will be both a diagnostic and treatment clinic run by funds obtained from the State Committee of Cancer Control.

Also, it was decided that a Liaison Committee to work with the Veterans Administration should be formed.

Following the business session, the society was joined by the auxiliary. The Owen Illinois Glass Company presented the sound picture entitled *"Doctor In Industry"*. After the movie, refreshments were served and the members enjoyed the entertainment afforded at the company club house.

HUDSON COUNTY

Harry J. Perlberg, M.D., Reporter

Hudson County Medical Society inaugurated its new season on October 1, 1946, when the first regular meeting of the official year was called to order by the president, Dr. C. E. McNenney, at the Masonic Club in Jersey City.

The following applicants were elected to membership: Dr. William A. Dasher, Dr. John J. DiGioli and Dr. Leo E. Fisher, all of Jersey City; Dr. Charles F. Baldini of Union City; and Dr. A. M. Sherman of Weehawken. It was announced that Dr. Fred Sachs of Jersey City had been passed by the Board of Censors for reinstatement.

Dr. McNenney introduced the speaker of the evening, Dr. Robert B. McGraw, Chief of Clinic and Attending Psychiatrist at Vanderbilt Clinic of Presbyterian Hospital, New York City. Dr. McGraw spoke on *The Treatment of Mental Illness by Electric Shock*. He classified various forms of mental illness according to their amenability to shock therapy and explained the technic of this mode of treatment in terms of voltage and length of time required, frequency, and effect upon the patient. He also described the manner of caring for the patient before, during and after treatment, and discussed concomitant physical conditions that merit careful consideration in determining the advisability of applying electric shock therapy.

Dr. McGraw's paper was discussed by Doctors Zitani, Doody, Stockfisch, Schorr and Comora.

Before adjournment, Dr. Londrigan, Chairman of the central committee of the Veterans Liaison Committee, briefly outlined the procedure that has been approved for establishing veteran examination centers throughout the state. The society approved his recommendation to appoint Drs. Tyndall, Evans, Ruoff and Butler as members of a corporate body authorized to draw up a contract with the Veterans Administration.

MONMOUTH COUNTY

Helen E. Jones, M.D., Reporter

The Monmouth Memorial Hospital was host to the *Monmouth County Medical Society* at its regular meeting on September 25. The meeting was called

to order by the president, DR. JAMES P. PREGNALL.

The scientific session was devoted to a symposium on poliomyelitis. DR. DOROTHY HORSTMANN, professor of preventive medicine at Yale University School of Medicine, was the first speaker. Her subject was *Epidemiology of Poliomyelitis.* The history of the disease was traced from the first records to the present. Dr. Horstmann then discussed the possible portals of entry and the possible vectors. The change of the age groups affected and the increasing incidence of the bulbar type was emphasized.

DR. ALFRED E. FISCHER of Willard Parker Hospital spoke on the *Variations in the Clinical Symptomatology of Poliomyelitis.* Dr. Fischer reviewed the three clinical groups: abortive, spinal and bulbar. The varied and bizarre symptoms and signs of this disease were illustrated.

Next on the program was a film demonstration of *Treatment of Poliomyelitis with Curare* presented by DR. NICHOLAS S. RANSOHOFF, attending orthopedist of the Monmouth Memorial Hospital. This treatment was perfected by Dr. Ransohoff in this hospital. The minutes flew as the progress of these first patients was followed. When the film ended, all felt that this was a good if not the best treatment of acute anterior poliomyelitis today.

A general discussion was opened by DR. FREDERICK R. THOMPSON of St. Luke's Hospital. Dr. Ransohoff answered the many questions which arose.

The business meeting followed. DR. HERRMAN graciously reported the latest developments in the medical care for veterans. DR. GRANVILLE JONES was unanimously elected to honorary membership in this society. The Woman's Auxiliary received a vote of confidence after DR. FEATHERSTONE made a report on its activities. DR. HAUT, DR. MAZZI and DR. DREFUS were elected to associate membership.

OCEAN COUNTY

H. Rinzler, M.D., Reporter

The Paul Kimball Hospital was host to the *Ocean County Medical Society* at its regular monthly meeting on October 9, 1946. DR. R. A. TAYLOR, the president, was in the chair. Eleven members of the society were present.

Upon the recommendation of the membership committee DR. R. R. GOVE of Brant Beach was admitted to junior membership and the meeting then went on to the discussion of the chief business of the evening, the *Ocean Plan for Veterans Medical Care.* This project is concerned with setting up suitable machinery, both clinical and clerical, for the examination of veterans claiming disability and applying for pensions. After discussion, the plan was accepted and the following Board of Trustees was elected tor its administration: Drs. Taylor, Szold, Hayden, Sickels and Dodd.

The speaker of the evening was MR. E. D. EASTON of the State Tuberculosis and Health Association who spoke on the use of x-rays in case finding. The presentation was chiefly from the historical viewpoint with Mr. Easton pointing out that the early opposition of many practitioners has been converted to active cooperation. At the close of his talk the Medical Society passed a resolution commending the Ocean County Health Association for its work.

Before closing the meeting it was decided that next month's regular session would include a dinner to which the Woman's Auxiliary will be invited.

UNION COUNTY

Edward G. Bourns, M.D., Reporter

A regular meeting of the *Union County Medical Society* on May 8, 1946, was called to order by the president at 9 p. m. The minutes of the previous meeting were approved as read. The resolutions on the death of Dr. Hubbard were read and received.

PAUL GEARY, M.D., thoracic surgeon, Bonnie Burn Sanatorium, discussed *Surgical Treatment of Chest Diseases.* Tracing the developments and advances of the past fifteen years, Dr. Geary described operative opportunities in the treatment of tuberculosis and various types of infectious processes. Slides illustrated the lecture.

Applications for membership were received from LIONEL A. GRECO, Scotch Plains; HAROLD S. YOOD, Plainfield, and A. T. WILLETTS, Summit. Candidates elected to membership were MILTON LANE, Union, and JOHN N. KENNEDY, Plainfield. JACK R. KAREL, Roselle, was accepted as a transfer from Cook County, Illinois.

Dr. Lane signed the Constitution and was introduced to the Society.

A detailed discussion was held on the recommendation of the Executive Committee to approve a public health survey in Union County. It was moved that the Union County Medical Society approve the public health survey proposed by the Chamber of Commerce and the Council of Social Agencies of Eastern Union County on a county-wide basis. The Society recommends favorable action and cooperation on the part of the local boards of health.

The matter of having county, state and national elected representatives appear before the Society to discuss medical bills and problems was taken up. It was moved by Dr. Burritt, seconded and passed, that a meeting be arranged between the Union County Medical Society and the various representatives. Senators Hawkes and Smith and Representative Case.

WARREN COUNTY

H. B. Bossard, M.D., Reporter

The annual meeting of the *Warren County Medical Society* was held at Morries Acres, October 8, at 11 a. m., with twenty members present. The meeting was called to order by the Vice-President DR. BOQUIST. Minutes of the previous meeting were read and approved.

DR. MITCHELL, a former member of the society asked for transfer to Ocean County. Request was granted.

DR. CHARLES RING, formerly from Bergen County, now practicing in Blairstown, was accepted to membership by transfer from Bergen County.

DR. A. ZUCK moved that a committee be appointed

to revise the by-laws. Motion carried. Drs. H. B. Bossard, A. C. Zuck and M. C. Marlatt were appointed as the committee of revision.

It was moved by Dr. Varney that a status of affilliate members be established and all such members must be active members of another county medical society.

Drs. William Skinner, H. I. Brown and L. Friedman, members of the Northampton County Medical Society (Penna.), were elected as affilliate members of Warren County Medical Society.

Dr. F. J. Bartolini was approved by the society for the Baby Keep-Well Clinic at Washington.

Drs. F. J. Bartolini, H. Baldauf and S. Kimmell were appointed to audit the Treasurer's books.

The Monmouth County Plan for veteran care was discussed and approved. It was moved by Dr. Bostwick that the society approve the action of the executive committee to form a unit with Hunterdon County for the examination of veterans and to incorporate as the Hunterdon-Warren County Unit.

Drs. P. Drake, H. Bossard and H. Smith were appointed as nominating committee, and brought in the following suggestions:

Dr. W. Boquist for president.

Dr. F. Bartolini for vice-president.

Dr. William Varney for secretary.

Dr. A. Zuck for treasurer.

Dr. J. Humbert for reporter.

Dr. William Varney, delegate for three years.

Drs. Boquist, P. Kassow and W. Bostwick were nominated alternate delegates to the State Society.

Dr. H. Bossard was nominated to the nominating committee with Dr. W. H. Varney, alternate.

Dr. Emery Krausz was nominated censor.

It was moved that the secretary cast the ballot and that all the nominees be elected. This was done. New officers will begin their terms on June 1, 1947.

Meeting adjourned to the dining room, where a turkey dinner was served to the members of the society and the ladies of the Auxiliary

DOCTORS NEEDED FOR OVERSEAS MISSION HOSPITALS

The worldwide medical enterprise of the Protestant Church is in urgent need of physicians for general hospitals, as well as specialists in various branches for teaching centers. There are appeals for personnel from every quarter of the globe. These include special calls recently from Liberia, Alaska, China, the Congo and the Cameroons, for general surgeons and physicians, as well as specialists—oto-laryngologists, thoracic and orthopedic surgeons, clinical pathologists, anesthesiologists, neuropsychiatrists and internists—for service on the staffs of Christian medical colleges in India and China.

Applicants should be members of one of the regular Protestant denominational churches and imbued with a spirit of Christian service. The average pay is $80 a month for a single person, double for married couples; which together with certain allowances and the provision of living quarters, permit of a fairly high level of living in the country to which the missionary is appointed.

Those interested are asked to communicate with the Secretary, Christian Medical Council for Overseas Work, 156 Fifth Avenue, New York 10, N. Y.

NEWS NOTES

Dr. William Carlos Williams of Rutherford, N. J., a member of the Bergen County Medical Society, and nationally known as a poet and author, received an honorary degree at the University of Buffalo on October 4. Dr. Williams received his honorary degree in company with Justice Jackson, Vannevar Bush, Owen Young and Dr. George Whipple.

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Latest methods in the diagnosis and treatment of allergic disorders will be reviewed at the convention of the *American Academy of Allergy* at the Hotel Pennsylvania, New York City, November 25, 26 and 27. All physicians are welcome to attend without payment of registration fee. Write to Dr. H. S. Baldwin, 136 E. 64th Street, New York City, for an advance copy of the program.

Dr. George O'Hanlon, Medical Director of the Jersey City Hospitals, has accepted the co-chairmanship of the New Jersey alumni of New York University's College of Medicine in their fund drive. The alternate chairman is Dr. William N. Barbarito of Jersey City.

• • •

A prize of $300 and two honorable mentions await the best essays on problems related to the thyroid gland. Papers may cover either clinical or research material, but should not exceed 3000 words. Copy should be sent to Dr. C. T. Davison, Doctors Building, Atlanta 3, Georgia, prior to December 31, 1946.

• • •

Dr. Henry M. Collier of Grenloch, N. J., has been elected to the Board of Governors of the American College of Chest Physicians.

WOMAN'S AUXILIARY

PRESIDENT'S MESSAGE

Mrs. Frederick G. Wandall

Now is the time for you, as Auxiliary members, to avail yourselves of information concerning the various state and federal health programs. There is a lull now, on the home front, due to the political calendar, but many pamphlets and articles expounding the virtues and faults of these several bills are being distributed to a health conscious public.

Let us take a fleeting glance at several of the more publicized bills. The Wagner-Murray-Dingell bill, as it now stands is dead. It will have to be changed before it can be introduced again, when Congress convenes in January. Be sure you know all the attributes of this compulsory health bill, and how it will affect the public if proper changes are not made. The Hill-Burton bill is, in part, law. Federal grants will be alloted states for hospital surveys, during the coming year. Another bill we should watch closely is the Taft-Smith-Ball health bill. This was introduced just before Congress adjourned, and is looked upon more favorably, because it gives the states more freedom in developing their own voluntary health plans.

These are merely glimpses into a very vital subject that concerns every physician's family in the United States. The air of mystery surrounding disease and its treatment is being lifted. The public at large is well informed. It is absolutely essential that we maintain state unity during this crisis in our husbands' profession. There are forces abroad which would completely socialize our institutions. We must be watchful lest we play into the hands of these. To this end let us not be credulous, but seek ever to know and to disseminate the facts concerning situations confronting us in medicine. We can present a woefully inept organization if we have failed to watch every straw in the wind indicating the forces at work.

EXECUTIVE BOARD MEETING

Mrs. Robert B. Walker, Chairman Press and Publicity

Forty members attended the first regular meeting of the Executive Board of the Woman's Auxiliary to the Medical Society of New Jersey, on October 14, at the State Society Headquarters in Trenton. Mrs. Frederick G. Wandall presided. The morning business session included complete reports of all state chairmen and county presidents.

Following a buffet luncheon, Mrs. Jesse D. Hamer, of Phoenix, Arizona, President of the National Auxiliary addressed the meeting. She spoke of the objectives that could be achieved by the National, State and County Auxiliaries.

We should consistently strive to increase our membership and encourage better attendance at our state meetings. Counties of small membership should never feel unimportant. Promote friendship in our own groups and be known in our community as friendly. If we have friendliness we will have unity.

Let us learn about the voluntary health insurance plans of each state. As Auxiliary members it is our duty to become acquainted with the details, so that we may talk intelligently and we should stand ready at all times to help with the promotion of such plans.

Always avail ourselves of the opportunity to promote health-education programs. Talks on health problems may be given by the members. Acquaint yourself with local health needs and cooperate with your Boards of Health.

The tools available to work with in your county programs are the *Bulletin*, official organ of the Woman's Auxiliary to the American Medical Association, *Hygeia*, and *The Handbook*. This is meant to be a working book.

Let us at all times strive to maintain the high standards of the medical profession and as we are privileged to be closely associated with it; let us share the responsibilities as well as the honors.

In closing, Mrs. Hamer expressed her pleasure and gratitude for the courtesies accorded her by the New Jersey State Auxiliary.

AUXILIARY REPORTS

Atlantic County

Mrs. Charles Hyman, Chairman of Publicity

The Woman's Auxiliary to the Medical Society of Atlantic County held its first fall meeting in the Hotel Traymore on October 11, 1946.

Dr. Lawrence A. Wilson, president of the Medical Society of Atlantic County gave a welcome message to the members and praised the good work being done by them.

Mrs. Frederick G. Wandall, president of the Woman's Auxiliary to The Medical Society of New Jersey gave an interesting talk and urged all members to work in close contact with the county medical society. She also urged the group to be active in the community and to instruct the public in health education and in the workings of the organization.

The meeting was conducted by Mrs. Charles Hyman, president, who also acted as program chairman.

The Auxiliary resolved to donate $100 to the occupational therapy department of the Atlantic County Hospital for Mental Diseases to purchase looms and other equipment for weaving.

Camden County

Mrs. W. F. Burns, Publicity Chairman

The *Woman's Auxiliary to the Camden County Medical Society* resumed activities on October first when the first regular meeting was held at the home of Mrs. Penrose Thompson, Haddonfield.

After welcoming the members, Mrs. A. Lincoln Sherk, the president, conducted a business meeting.

Mrs. A. Haines Lippincott gave a resume of the National Convention held in San Francisco, and Mrs. Thomas McConaghy reported the state conference held in Trenton, September 5th.

Mrs. Banks Baker read letters of thanks received from the Centenary Tabernacle Methodist Church, The Child Center, and The Camden County Dental Health Committee, all of whom received contributions from the organization.

March 3, was announced as the date for the Annual Card Party with Mrs. William Braun as General Chairman. Mrs. Henry Tatem, Public Relations Chairman, reported the all-day Public Relations Meeting would be held March 25.

After the business meeting Mrs. A. Gomersall Pratt, Program Chairman, introduced the speaker, Miss Annette Cornell of the New Jersey Bell Telephone Company who discussed *Lesser Legends of New Jersey*. Miss Cornell gave a highly instructive talk imparting important facts about the early history of New Jersey. She spoke about *tele-news*, a small pamphlet, which is enclosed with monthly bills from the telephone company. It gives us an opportunity to review much of the early history of our state since an important historical event is reported each month.

Hudson County

Mrs. Sidney Chayes, Chairman of Publicity

The Woman's Auxiliary to the Hudson County Medical Society opened the season's activities with a membership luncheon, October 7, 1946, at the Young Women's Christian Association in Jersey City.

Mrs. Edward Murphy, president, greeted the guests and presided at the business meeting which followed the luncheon.

Mrs. Frederick Wandall, president of the state society, was the special guest of the day. She addressed the members on the duties of an auxiliary and the best way to serve our county medical society.

Mrs. Bryson Ainsley, membership chairman, introduced seven new members: Mrs. Solomon Ben-Asher, Mrs. Louis Marella, Mrs. John Doyle, Mrs. Morris Breserv, Mrs. Samuel Schneider, Mrs. Samuel Kooperstein, all of Jersey City, and Mrs. John Fabriele of Bayonne.

A musical program was enjoyed. Mrs. William Gleason, program chairman, presented Miss Beatrice De'Marco, vocalist, accompanied by Mrs. Harry Peariberg and Mrs. Edward Fleckenstein, pianist.

Middlesex County

A talk by Dr. Anna Starr, director of the psychology clinic at Rutgers University, was the feature of the October 16 meeting of the *Woman's Auxiliary to the Middlesex County Medical Society*, held at the home of Mrs. Nathan Karshmer. Dr. Starr explained that there is purpose behind all children's behavior and therefore motives must be understood. Parents should not consider themselves as traffic cops in either cultural or physical well being, the speaker said and must learn to consider the youngster as an individual entity, not merely as a charge.

Monmouth County

Mrs. Joseph E. Bossone

The *Woman's Auxiliary to the Monmouth County Medical Society* held its first luncheon-meeting of the fall season at the Berkeley Carteret Hotel, Asbury Park, Tuesday, September 17. Mrs. Norman Nathansan presided.

Many new members were welcomed into the Auxiliary and Mrs. Nathansan took this opportunity to stress once again the fact that "the purpose of the Auxiliary is to assist the Medical Society in such a manner it may suggest or approve and to promote good fellowship among physicians' families".

The program for the coming year was discussed. The principle issue being a drive to increase the number of donors to the Fitkin and Monmouth Memorial Hospitals' blood banks. Mrs. Pregnall of Fitkin and Mrs. Rocco of Monmouth were appointed general chairmen to be assisted by the following committee:

Fitkin—Mrs. Barnett, Mrs. Bornstein, Mrs. Graber, Mrs. Sevell, Mrs. Feutan, Mrs. Levin.

Monmouth—Mrs. Baer, Mrs. Siegall, Mrs. George, Mrs. Bossone, Mrs. De Maree.

Other appointments were Mrs. Joseph Bossone, press and publicity chairman; Mrs. Eli Long, goodwill chairman, and Mrs. Feutan, next month's hostess.

Tuberculosis Abstracts

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XIX **November, 1946** **No. 11**

IT IS not generally recognized that tuberculous patients have a unique opportunity for constructive thinking and study while relaxing and resting their bodies. Although physical activity is restricted in the treatment of tuberculosis it is possible for the patient, through directed education under medical supervision, to leave the hospital better equipped to face life than when he entered it. This process of education is known as rehabilitation, which has been defined as the restoration of the handicapped to the fullest physical, social, vocational and economic usefulness of which they are capable.

REHABILITATION OF THE TUBERCULOUS

Rest is fundamental in the treatment and cure of tuberculosis. The period of rest usually lasts for many months and it is during this time that the rehabilitation of the patient should begin. This may mean the planning of a completely new mode of life. Almost always it also includes some kind of productive work in order to earn a living. Since rest, with only a limited amount of physical effort, is necessary to regain health and to continue in health, the new life must bring to the patient the maximum of financial return with a minimum amount of physical effort.

This can be accomplished most easily by improving the patient's knowledge and education. The fact that a patient is lying in bed resting his body does not mean that his mind is at rest. It is natural for him to worry about the future, and now is the time for rehabilitation to begin. If the mind is occupied with constructive thinking, the patient's physical condition improves more quickly, and a plan for his future may be evolved. Constructive reading and study are part and parcel of rehabilitation.

A young laborer admitted to the hospital with tuberculosis came to realize he would never again be able to do hard physical labor. He was intelligent and cooperative, so he studied, read and took a correspondence course while in bed. Later when his disease was cured he was able to qualify as boss of the laborers and soon afterwards he became a contractor.

Surprisingly many people have a latent unrecognized ability which the rest period brings out. As they relax they think and from this comes creative impulses. Many of the world's geniuses have been men and women with tuberculosis. Is the genius due to some mysterious action of the tubercle bacillus? Or is it due to the rest and the opportunity to think? Scientists are uncertain, but it would seem that the long enforced period of relaxation and the consequent opportunity to think, to meditate and to take stock of one's abilities might be the real answer.

The mind continues to function while the body is resting, in spite of all efforts to keep it quiet. If it is directed toward constructive thinking, a fuller, happier life will result. The more information and intelligence a person has, the more valuable a worker he becomes. There is no reason why the thoughtful patient should not gain from his enforced rest. Incidentally his future health is protected by rehabilitation because he has learned to utilize his mind and to conserve his physical strength. In many tuberculosis hospitals, courses in high school subjects and reviews in elementary studies are given. These are considered as important as food, rest and surgical treatment.

Occupational therapy focused on arts and crafts is not entirely adequate. For, although it keeps the patient's hands and mind occupied while in the hospital, it brings little financial return, and rarely leads to a future occupation for the patient. Today we speak of vocational therapy, which means treatment of the patient's mind through

preparing him for a vocation which he can utilize when he is ready to return to the competitive world.

Men and women with tuberculosis do not differ essentially from men and women who are not ill. But their disease imposes upon them restrictions and problems from which the well man is free. It is with these problems and restrictions that the rehabilitation of the tuberculous deals.

Rehabilitation is a process of education by means of which the patient arrives at the best possible adjustment to his handicap. While this adjustment may be achieved alone, it is one which is achieved more easily with help and direction.

There are four aspects of the rehabilitation of the tuberculous: medical, psychological, social and economic. On the medical side, the patient should have an intelligent knowledge of tuberculosis and of his own disease. He should know that even a small amount of infection demands a great amount of care. He should learn about curing, and how to cooperate with the nurses and doctors. Although he wishes to be active as soon as possible, he must learn that the physician alone can decide when his rehabilitation is to start.

The psychological aspect is perhaps the most difficult and one of the most important. The patient learns that tuberculosis is a recurrent disease and this usually frightens him. He worries over possible ostracism because people fear tuberculosis. He is separated from normal daily contacts. For these reasons this period should not be empty of incentive, plans and hopes. Bed rest by itself will not produce relaxation, nor is there any speedy road to recovery. It requires a seemingly endless amount of courage, perseverance and understanding.

The social problems will range from the boy or girl required to leave school or college to the family losing its wage earner; and from the ill worker who believes his job too good to leave to the patient willing to go to the hospital but forced to remain on a long waiting list for a bed.

Lessened earning power is costly not alone to the individual but also to the community. Hospitals bear a share of the costs of the illness, but society as a whole pays the bills. Skill in any line of work grows rusty during long periods of illness, and this human asset is one that business and the community can ill afford to lose.

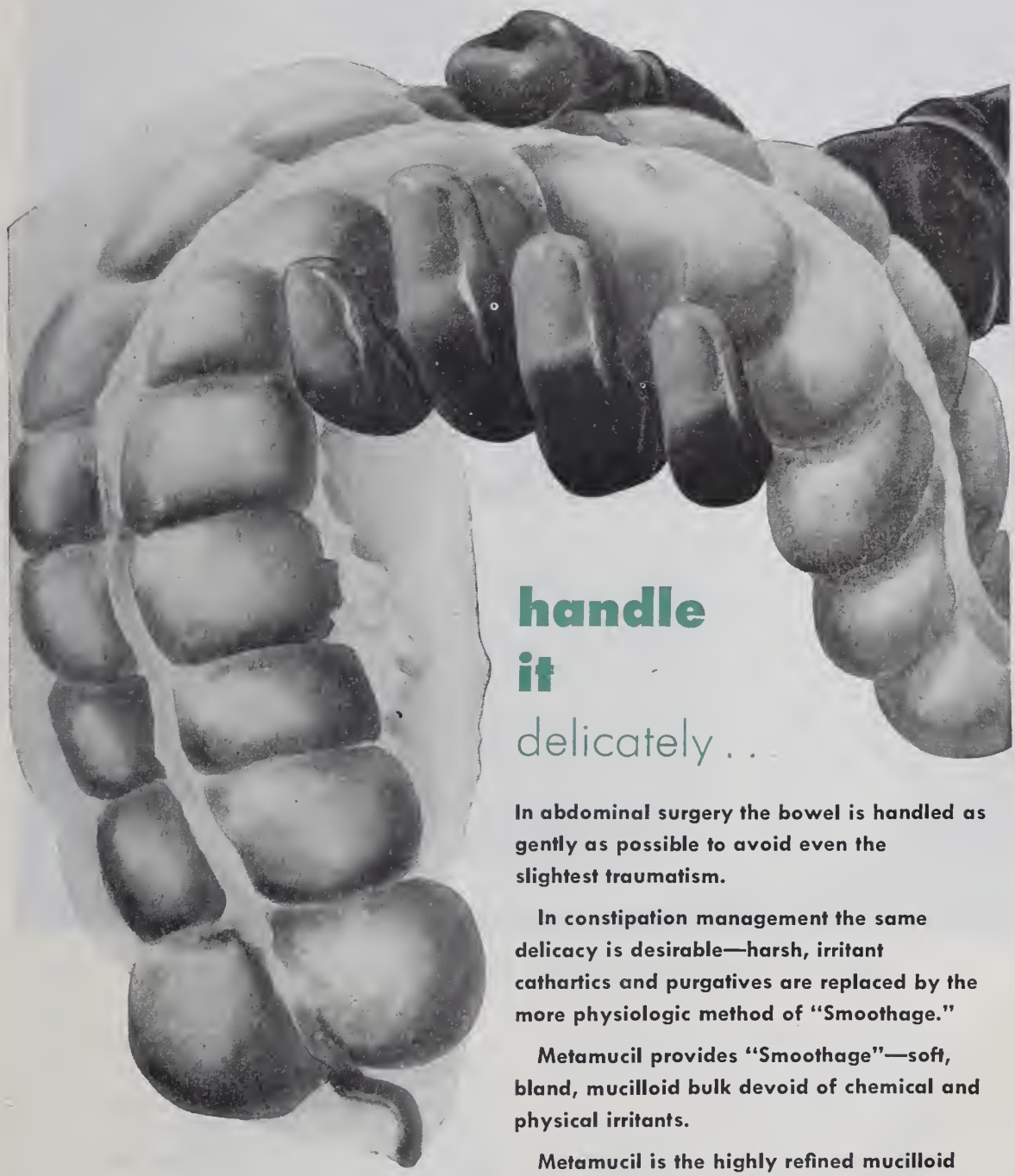
Rehabilitation works with the individual and with the community to convert ill-founded fear into well-founded hope. It works under medical advice and on the basis of total physical, mental and emotional capacities, building a practical program of activity. It makes use of all available resources toward an eventual life plan compatible with the patient's health, interests, abilities and ambitions. The community must be taught that although rehabilitation does cost money, the lack of it costs more, not alone in illness, but in dollars and cents.

Rehabilitation of the Tuberculous, H. St. John Williams, M.D., New York State Journal of Medicine, March 15, 1946.

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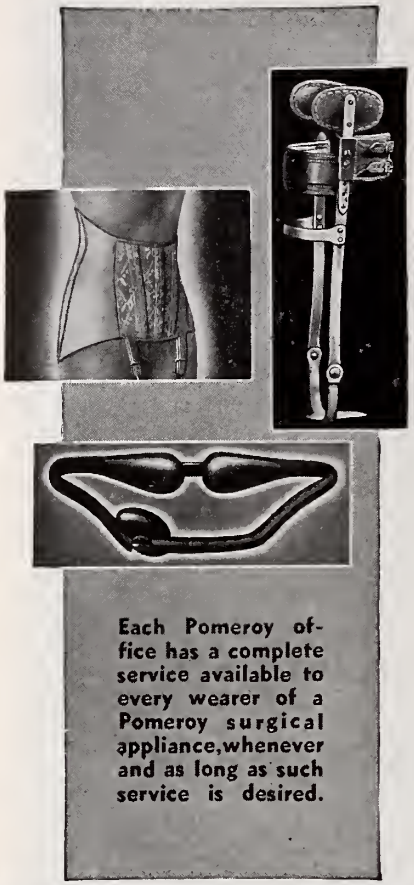
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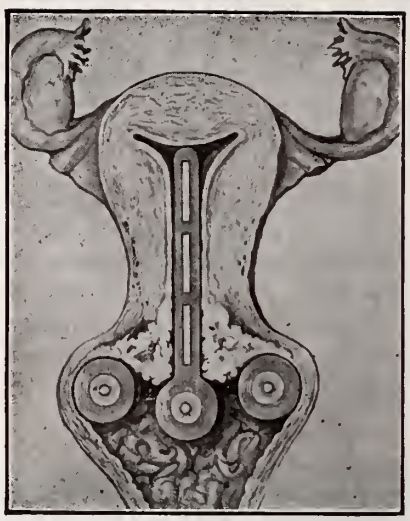
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*Stare, F. J., and Thorn, G. W.: Protein Nutrition in Problems of Medical Interest, J. A. M. A. *127*:1120 (April 28) 1945.

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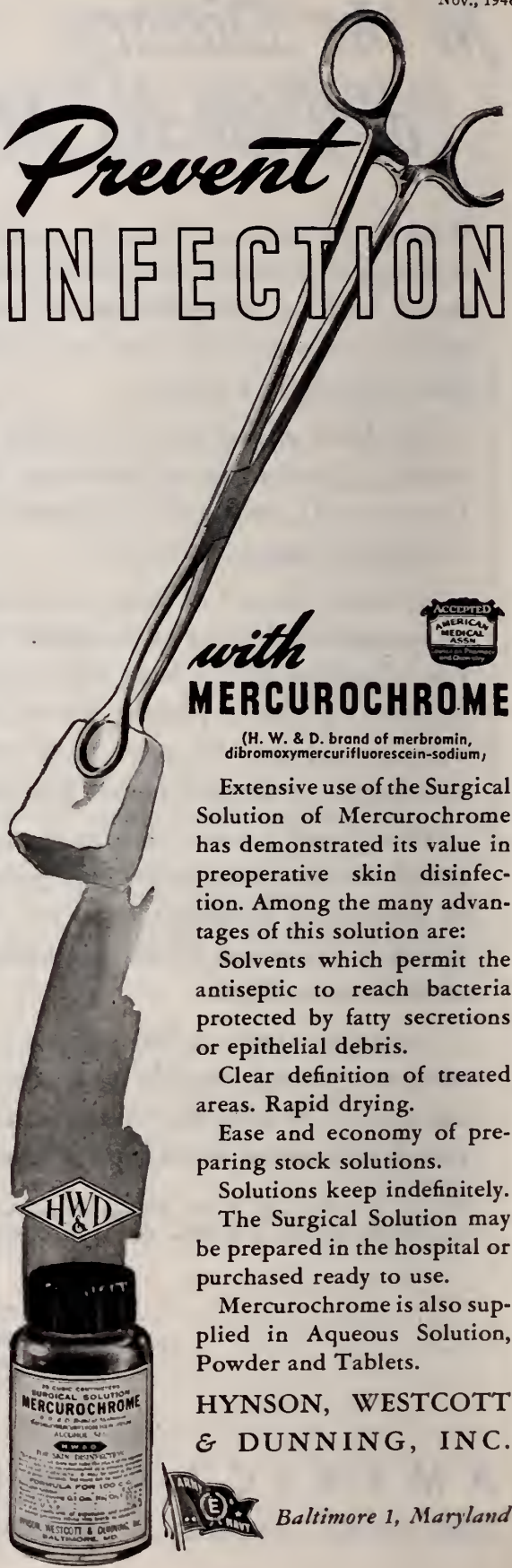
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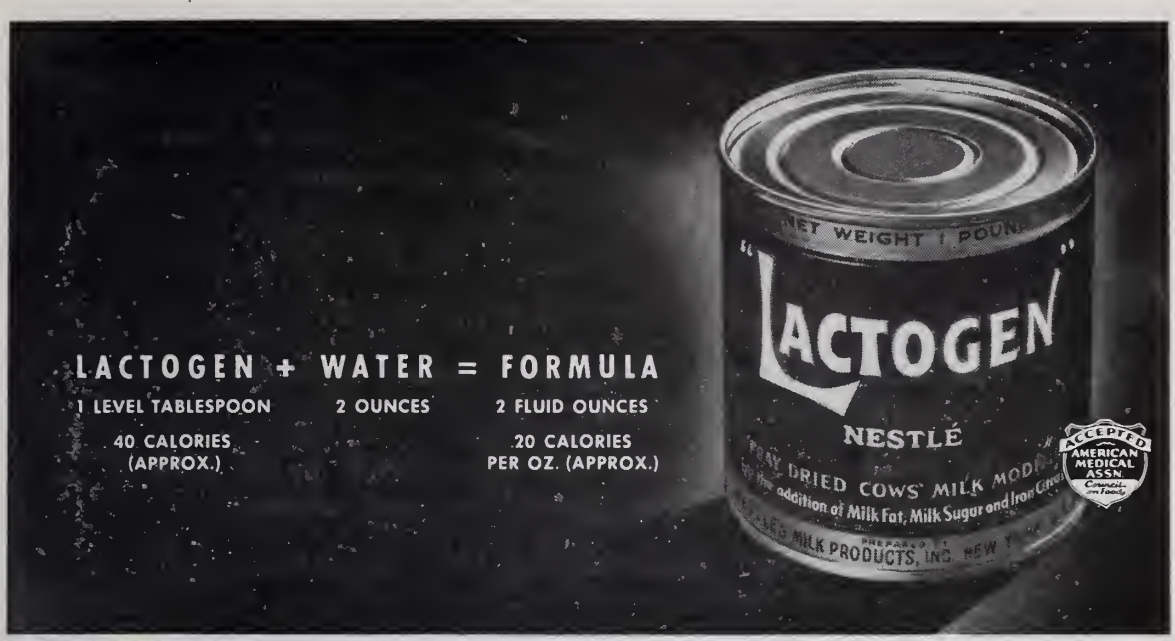
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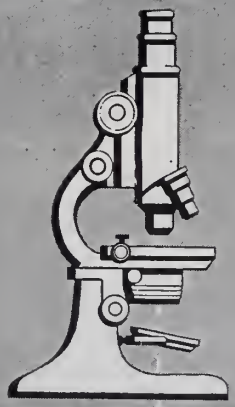
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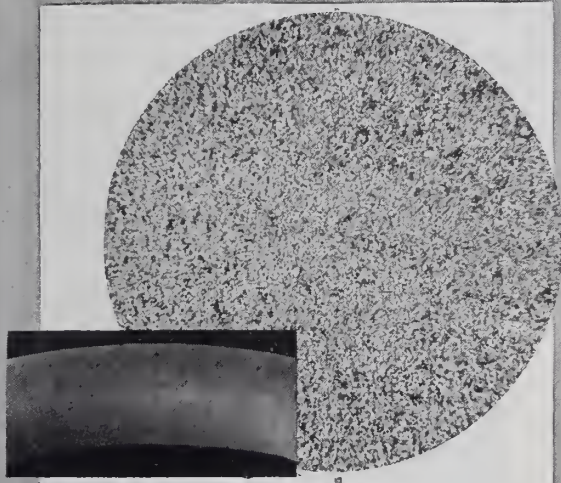
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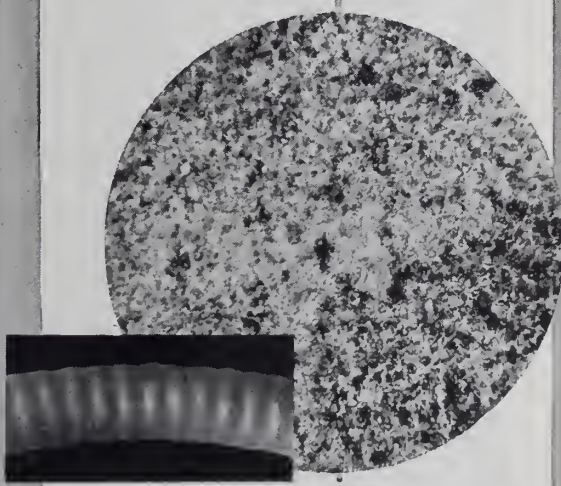
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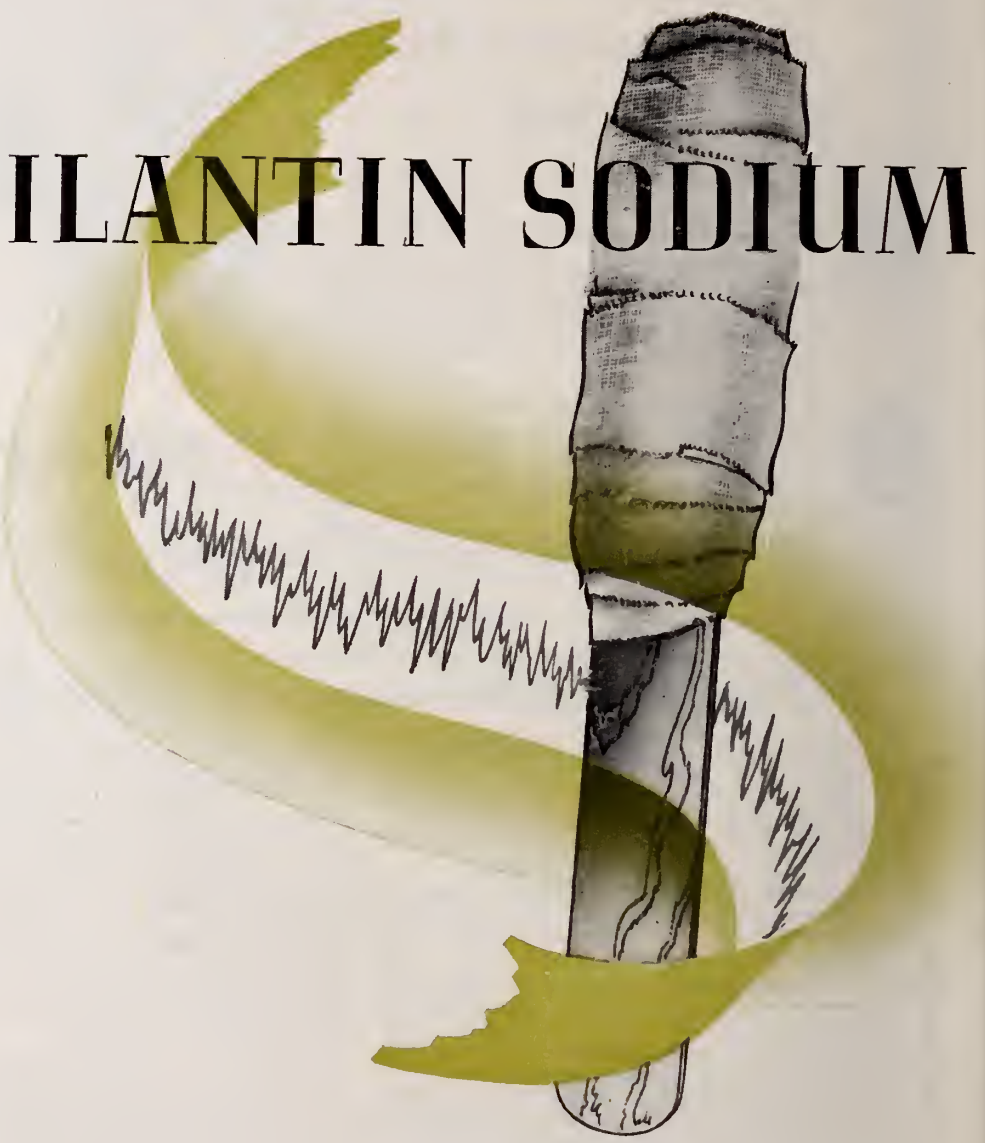
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VOL. 43, NO. 12 DECEMBER, 1946 Subscriptions, $3.00 per Year
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Place of Publication, Printing and Mailing:
12 South Day St., Orange, N. J.

Editorial and Executive Offices of the Society:
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1. Smull, K., Wegria, R., and Leland, J.: The Effect of Sodium Bicarbonate on the Serum Salicylate Level, J.A.M.A. *125*:1173 (Aug. 26) 1944.

2. Coburn, A. F.: Salicylate Therapy in Rheumatic Fever, Bulletin Johns Hopkins Hospital *73*:435-464, December, 1943

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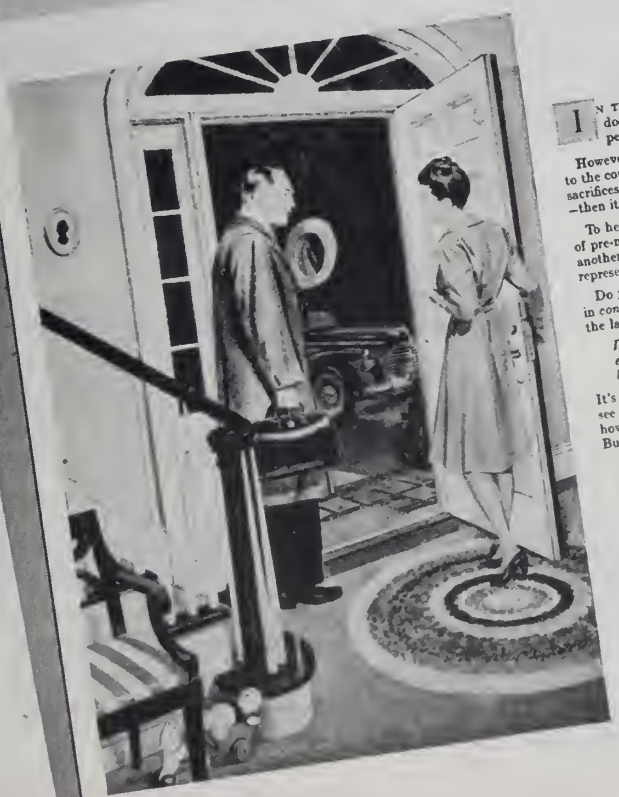
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Wier, F.A.: Clin. Med & Surg. 43:217.

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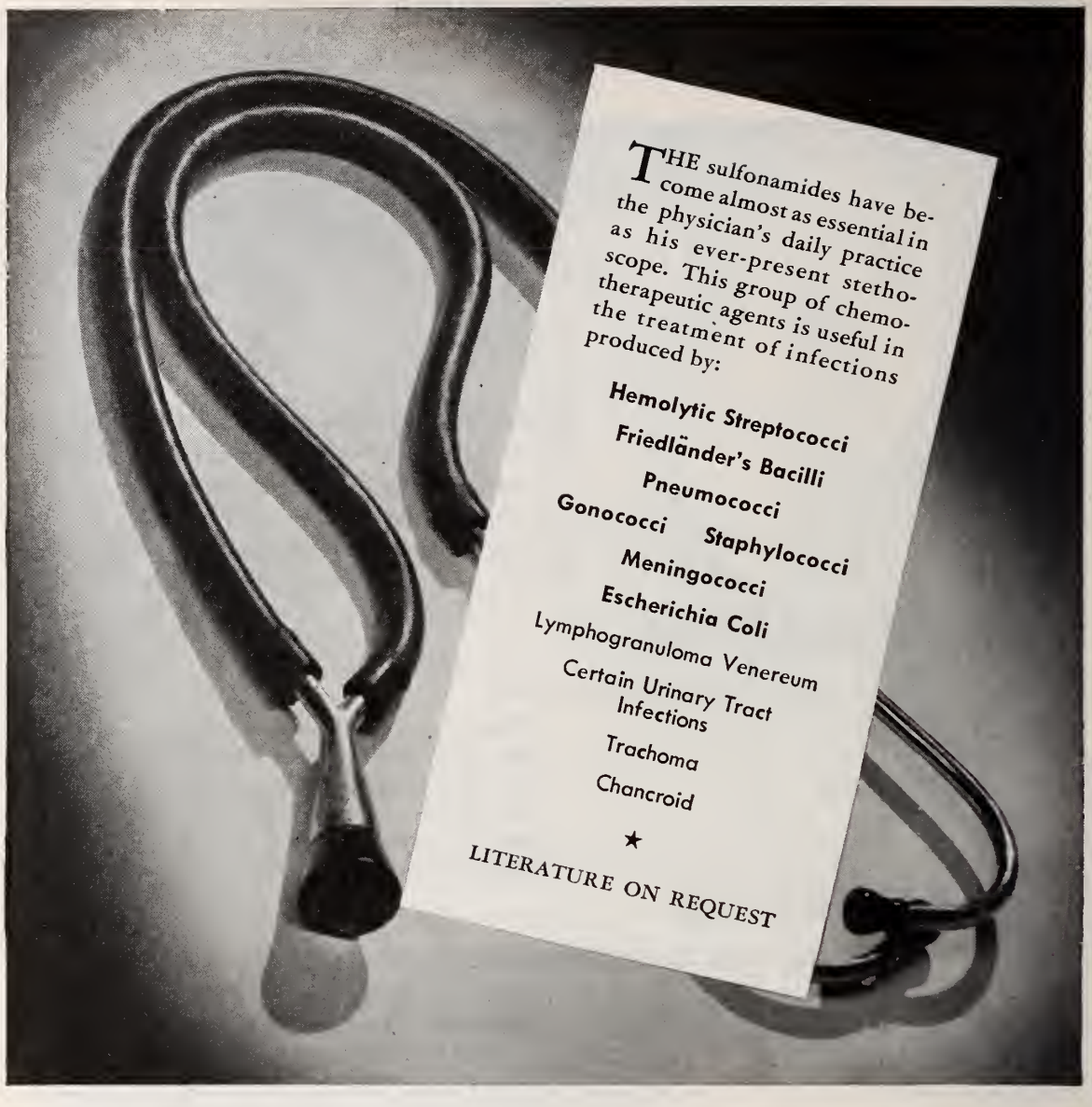
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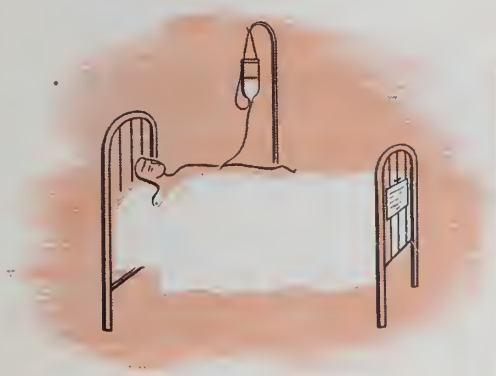
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Editorial: Surg., Gynec. & Obst. 83:259, 1946



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Koop: Geriatrics 1:269, 1946

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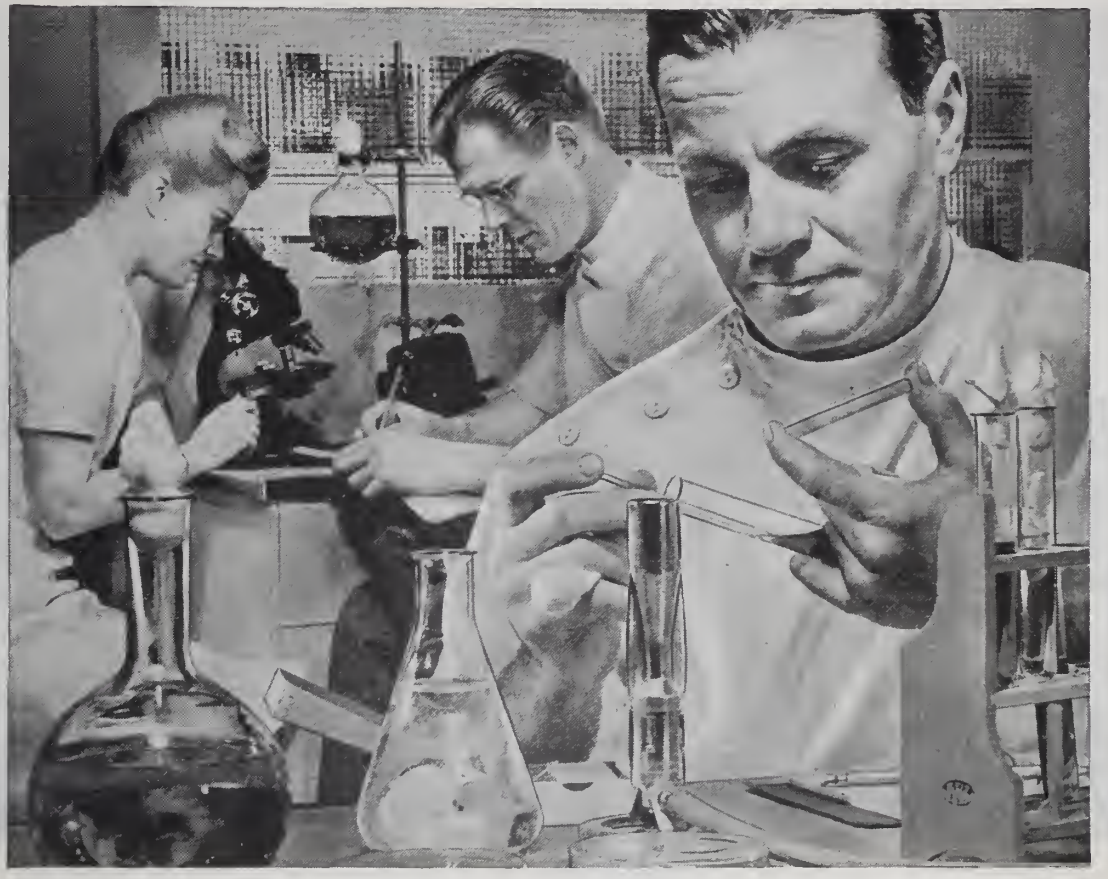
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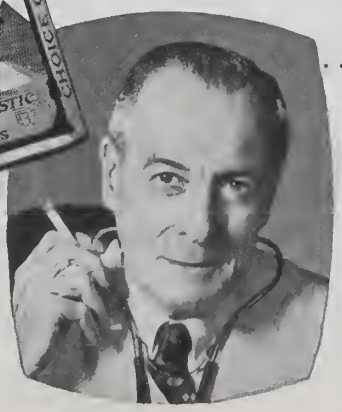


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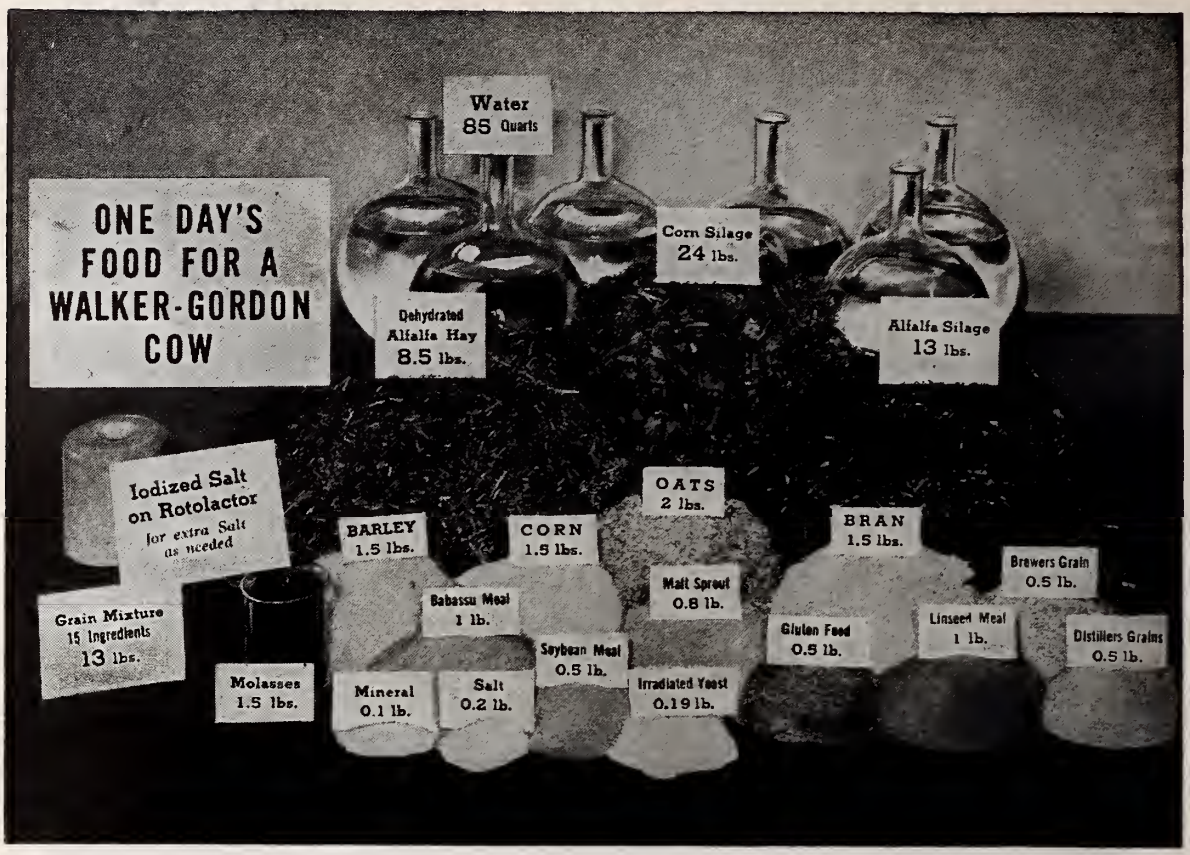


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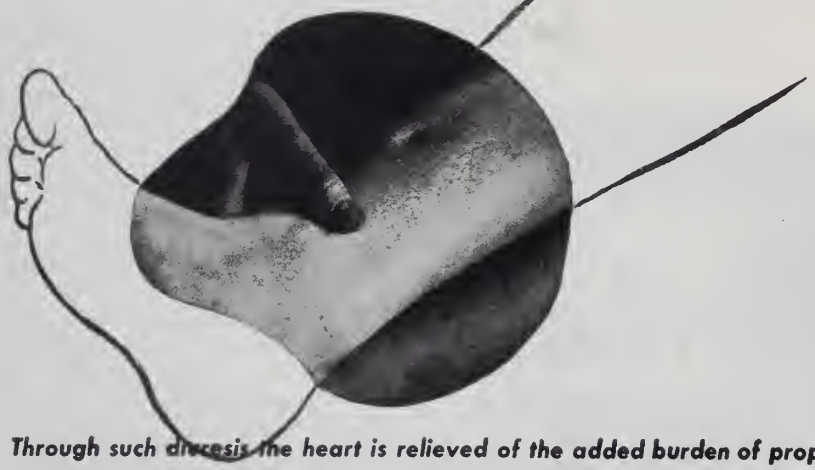
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THE JOURNAL
OF
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Published Monthly Since September, 1904

Whole Number of Issues, 508

Under the
Direction of the
Committee on Publication

Henry C. Barkhorn, M.D., Chairman

Henry A. Davidson, M.D., Editor

Place of Publication, Printing and Mailing—12 South Day Street, Orange, N. J.
Editorial and Executive Offices of the Society—315 West State Street, Trenton 8, N. J.; Tel 5776
Send all communications to the Trenton Office
Each member of the State Society is entitled to receive a copy of The Journal every month.

Vol. 43, No. 12 December, 1946 **Subscriptions, $3.00 per Year**
Single Copies, 30 Cents

GOODBYE TO THE GRAIN

Four centuries of medical history have ground to a stop with the decision that the grain and drachm must follow the apothecary's "scruple" into the oblivion of obsolescence. Already the Pharmacopeia Committee has reconstructed its conversion tables with the Gram (not the grain) as the point of orientation. The American Medical Association press has abandoned the apothecary's system even as an alternate notation. As new drugs appear on the market, only the metric dosage will be printed on the label. And the current crop of medical students are giving their patients four cubic centimeters of liquid medicine and glibly quote the dose of aspirin as "three hundredths of a Gram".

At the risk of being called reactionary, we here enter for the record a modest word of protest. Perhaps some future antiquarian may recognize this as the last word ever spoken in defense of the apothecary's system. We insist that the grain is a more useful medical weight than the Gram or milligram. Most solid medications have a dosage on the order of 5 or 10 grains, the bromides, for instance, the chlorides, the sulfates, the salicylates, even the sulfa drugs. The corresponding metric dose is hard to remember and confusing to use: three tenths of a Gram or 300 milligrams. The potent alkaloids are dramatically pictured by their tiny fractions of a grain. Surely it is easier to remember and express the dose of atropine, for instance, as 1/100 of a grain than to say sixty-thousandths of a Gram. The grain is so comfortable a unit in medical posology that it must have been worked out by the apothecaries themselves precisely for that purpose. The Gram is rooted only in the empty notion of the weight of a mass of water in a cube a certain fraction of the earth's meridian on a side.

The entire range of drugs stretches compactly backwards and forwards from the grain as the center point. It sweeps from 1/400 grain to 15 grains. The corresponding metric range is from 15 hundredths of a milligram to just one Gram.

Compared with the centrally placed grain, we find the milligram unit almost at the bottom of the dosage scale and the Gram unit at the very top of the range.

And how now shall we express liquid dosage? A teaspoonful is close enough to a drachm for most clinical purposes. The standard three ounce bottles thus neatly include 24 teaspoonfuls—about a week's supply at the traditional "once after each meal". But how is it with cubic centimeters? Here is an exercise in the higher mathematics. You write for 90 cubic centimeters and then divide this by four because the dose is four cubic centimeters and that gives you 22½ and then you divide again by the daily frequency of three to reach the conclusion, after much computation, that the bottle contained about a week's supply; a conclusion that was instantly obvious without a slide-rule when you used the drachm-teaspoonful basis.

The equation of the minim to the drop could be made as accurate as you wanted by selecting the appropriate dropper. Having done this, you could prescribe minims as drops. In the metric system how can you comfortably make use of the fact that this drop is now six-hundredths of a cubic centimeter?

The grain, the minim, the drachm, the ounce—they have labored handsomely for many a century in the service of medicine and pharmacy. A doctor felt that he was indeed practicing one of the esoteric arts when he added that downbeat of a pen stroke that made a minim symbol out of a plain "m"; or annexed that extra flourish to the top of the symbol for "ounce". The grocer had his ounce too, but it was a humble "oz" and not the very special ℥ which belonged only to the disciples of the healing arts. The Gram has no such association with pharmacy or medicine. It may be used alike by purveyors of frankfurters or salesmen of spangles. A Gram can be a Gram of anything. But the grain has always been used to denote the fine things of life—its valued jewels and potent medicines. The grain indeed refers only to precious stuff; a grain of gold perhaps, a grain of medicine, a grain of common sense.

THE DOCTOR AS A HEALTH POLICEMAN

Patients frequently ask their doctors about the virtues of a patent medicine, vitamin product or allegedly therapeutic gadget which they have seen advertised in newspapers or car cards or about which they have heard over the radio, sometimes to music. Most physicians are too busy to investigate the claims and impatiently dismiss the query with the statement that these products are frauds. The difficulty is that this cavalier disposition of the question leaves the patient unsatisfied and often indeed gives him the feeling that the physician is merely expressing resentment at competition. It therefore behooves the alert practitioner to acquaint himself with the better known nostrums which so insistently assail the eyes and ears of the American public. Thus a widely advertised depilatory may in fact remove hair. Asked about it the physician should certainly be able to say that this product removes hair by reason of its caustic action, or by reason of bleaching the hair into invisibility or that it accomplishes depilation by catching the hair in a sticky mess so that when the salve is removed the hair is torn off with it. If the doctor says he does not know how the depilatory works the effect is not to discourage the patient but to make him feel that the doctor is badly informed. If the physician wants to advise the patient honestly he must know something of the claims and the contents of the nostrums involved. The recent

publicity given to demerol is an example. Although the well read physician knew from the beginning that this was a habit forming drug, many of us were caught unprepared when Paul de Kruif recklessly characterized it as "God's own medicine" and assured a gullible public that it was not habit forming. The physician who had been alert to modern advances in biochemistry knew something of the composition of demerol and was in a position to advise the patient honestly. Still fresh in our minds is the wave of popular interest in the freezing treatment of cancer, the use of dinitrophenol in obesity, surgery for hypertension and various other procedures which, in good hands, have proved sound but which are frought with danger to the public if used indiscriminately. In many of these cases the layman knows about the product before the doctor does because he reads of it in the newspapers whereas the physician likes to wait until the information is available in the scientific press. Since this may not occur until many months after the initial enthusiastic announcement to the public, we are too often in the position of being obliged to say: "I never heard of it". While no one wants the doctor to get his medical information from the newspapers, certainly the careful practitioner will make it his business to find out something about any widely hailed therapeutic claim or universally advertised drug. The American Medical Association will furnish this information to any physician who takes the trouble to send in a query. It takes time and effort to keep up with the advancing front of medical mythology but any doctor who sees himself as his private patients' health adviser can do no less.

VITAMINS AND VITALITY

Little publicity has been given to the saga of Balto the dog-mascot to a dispensary on the Alaska highway. Balto, it seems, chewed his way into a supply carton and swallowed several hundred vitamin tablets. What happened to Balto? Nothing. He did not zoom over the tundra or chase away a pack of wolves. Nor did he burst from any internal explosion. To the dismay of the pharmaceutical industry, Balto remained quite the same after his vitamin orgy as before. This unintended experiment in the efficacy of vitamins was matched on a smaller and more realistic scale, earlier this year when Bransby and his colleagues *(British Medical Journal,* 1:193, February 1946) published the result of a study of supplementary vitamin feedings to children. One group of children received a capsule containing an inert placebo. The other group received a capsule loaded with vitamin A, riboflavin, ascorbic acid, vitamin D and nicotinamide. The project was faithfully followed for a full year. The supplementary vitamin, according to these authors "had no consistent effect on growth, strength, endurance, fatigue, clinical conditions or absenteeism from school".

This does not mean that a clinical syndrome would not have resulted had the diets been deficient in vitamins. It does suggest, however, that the available diets, even in contemporary Britain, have all the vitamins that the organism can utilize. And it does make one wonder what the public is getting for the millions of dollars now being spent on unprescribed supplementary vitamins bought over the counter as a result of colorful window displays, coaxing advertisements and singing commercials.

ORIGINAL ARTICLES

MEDICINE DURING WORLD WAR II *

PERRIN H. LONG, M.D., Baltimore, Maryland

It would be premature at this time to make sweeping statements concerning medicine during the war. It is too early to assess accurately the eventual importance of many of the scientific investigations which were carried out during the last five years, and the effects of the war upon medical education and upon the professional qualifications and training of doctors are just beginning to emerge. However, enough data are at hand to permit a preliminary discussion of this subject.

RESEARCH

One of the first effects of the war was to shift the emphasis in medical investigation to problems concerning the care of the wounded, the prevention and treatment of infectious diseases, and to those physiologic and psychologic problems which arose from placing individuals in exotic environments. With this change in emphasis came also a shift from an individualistic type of research to that conducted by groups of investigators, whose activities were coordinated for the common good. This was necessary that time might be saved, and reduplications of effort avoided. Since there were many practical questions which had to be answered, research largely was concerned with new applications of existing knowledge, rather than with the search for fundamental principles.

It may be said that while an adequate liaison and a satisfactory system for the exchange of technical medical information was maintained between the civilian agencies of certain of the Allied Nations, this was not always true as far as certain military agencies were concerned. While objections were not made officially by the War Department to the receipt of classified military medical information by responsible civilian investigators in this country, restrictions were placed upon the official exchange of such information. As a direct result, information was withheld which was vital for the proper planning and execution of civilian medical research programs which were designed to aid our Armed Forces. It must be stated in all fairness, that the coordinated research program upon malaria was a notable exception to this general policy. A great deal of information covering the professional and research aspects of medicine, surgery, neuropsychiatry, preventive medicine and nutrition, which was embodied in special reports, Sanitary Reports and Essential Technical Medical Data reports, was received from overseas theaters of operations by the office of The Surgeon General. Certain of the data contained in these reports would have greatly assisted those who were planning research programs. They were unavailable because they had been classified as "confidential" or "secret". Not until the summer of 1945 was this type of data made *freely* available to accredited civilian agencies. The policy of not making such data freely available to accredited civilian investigators created an intellectual vacuum, a situation which should be considered intolerable in any concept of total war.

PENICILLIN

There can be little doubt of the outstanding importance of the experimental and clinical development by Florey and his associates,[1] of Fleming's [2] observations upon the anti-bacterial effects of penicillin. As the first of the antibiotics, it has revolutionized the treatment of many diseases and its use has altered the prognosis in patients with certain types of infection who previously had a very poor chance for survival. As a result of the war, clinical research upon the uses of penicillin was accentuated, while fundamental studies upon its pharmaco-

* Read before Annual Meeting, The Medical Society of New Jersey, May 21, 1946.

1. Chain, E.; Florey, H. W.; Gardner, A. D.; Heatley, N. G.; Jennings, M. A.; Orr-Ewing, J., and Sanders, A. G.: Lancet 2:226, 1940.
2. Fleming, A.: Brit. J. Exp. Path. 10:226, 1929.

logic and its biologic properties were held to a minimum or neglected altogether. While extensive investigations were being made upon the chemical nature of the various types of penicillin, the results of these studies were shrouded in war-time secrecy, and the investigators who were interested in the biologic properties of penicillin only tardily received information concerning the chemical nature of pure penicillin (and practically none of it for biologic and pharmacologic investigations). The accentuation of clinical research resulted in increasing demands for penicillin. The performance of the American pharmaceutic, biologic, chemical and distilling industries in meeting this demand by producing penicillin in fantastic amounts was outstanding. However, no real check was made on the type of penicillin which was being produced. Shortly after the end of the war, certain fundamental information concerning the chemical nature of the penicillins was released.[3] In this report it was revealed that four main types of penicillin existed, all with different chemical formulae. A review of the literature at the time this information was released showed that adequate studies concerning the pharmacologic and biologic properties of penicillin F, G, K and X were essentially lacking. Welch et al.[4] had demonstrated that crystalline penicillin X was three to five times as effective as penicillin G in protecting mice against 10,000 lethal doses of pneumococci, and that crystalline penicillin X was about one-third more effective, unit for unit, in the treatment of gonorrhea than was a commercial penicillin. These workers also noted that penicillin X was excreted more slowly in the urine than was commercial penicillin. Their observations were confirmed by Ory, Meads and Finland[5] who found that most strains of Group A hemolytic streptococci, gonococci and meningococci were from two to eight times more sensitive to penicillin X than to the commercial penicillin which they were using as a control. Strains of pneumococci and of Streptococcus viridans were also found to be more sensitive to penicillin X. These observers also noted that the levels of penicillin activity in the serum were better maintained when penicillin X was administered and they considered it to be "probably more effective in gonococcic infections".

These studies, scant though they are, clearly indicate that therapeutic and pharmacologic variations exist among the different types of penicillins. As time has passed it has become evident that the use of the term "unit of penicillin" which was based upon the effects of the antibiotic upon a single strain of staphylococcus, has been misleading. It has also been deleterious because it has placed a premium on the qualitative creation of "units of penicillin" with little or no reference to the quantitative character of the product. It might be asked at this point—Well, what does all this mean? The answer is that as the result of the initial neglect in carrying out fundamental studies upon the pharmacologic and biologic properties of the various types of penicillin, physicians today must use unkown mixtures of penicillins. They have no assurance that the mixture of penicillins which they employ will contain a preponderance of the type of penicillin which is most effective against the infection from which their patient is suffering. Fortunately, this error in the development of penicillin has at last been recognized, and research is in progress upon its fundamental properties.

STREPTOMYCIN

It is too early to assess the eventual therapeutic role which will be played by streptomycin.[6] However, from the evidence now at hand, it would seem reasonable to say that streptomycin is a valuable agent in the treatment of certain types of urinary tract infections and in systemic infections produced by some species of gram-negative bacilli. Its absolute value in the therapy of tuberculosis has not been established.

TREATMENT OF SHOCK

The treatment of the wounded in World War II was superior. All have heard of the marvels wrought by plasma and whole blood, the sulfonamides and penicillin. However,

3. Science: 102:627, 1945.
4. Welch, H.; Putnam, L. C.; Randall, W. A., and Herwick, R. P.: J. A. M. A., 126:1024, 1944.
5. Ory, E. M.; Meads, M., and Finland, M.: J. A. M. A. 129:257, 1945.
6. Waksman, S. A.; Bugie, E., and Shatz, A.: Proc. Staff Meet., Mayo Clin. 19:537, 1944.

these preparations are but adjuvants to surgical therapy and in any discussion should be primarily considered as such.

The development of resuscitation therapy for the prevention and treatment of shock and of replacement therapy for the maintenance of the blood in the seriously wounded has been an interesting story. Most of the properties of whole blood, plasma, and serum in the prevention and the treatment of shock were well known prior to 1939, and hence, the problems at the beginning of the war in respect to these agents were those of efficient utilization and production. On the basis of knowledge and conditions existing in 1941, it was deemed advisable to select dried plasma as the agent of choice for use in the resuscitation of the seriously injured, and the aid of the American Red Cross was enlisted for the procurement of the quantity of blood which was necessary to assure adequate supplies of plasma for the armed forces.

It had been noted by the British in the Middle East in 1941 that the administration of plasma while being valuable as a first aid measure in combatting shock, did not bring about the over-all favorable results which were noted following the administration of whole blood to seriously injured casualties. This observation, which was not new, substantiated the British organizational concept of the need for blood transfusion units to provide adequate amounts of whole blood in theaters of operations. The British point of view concerning the need for whole blood was sustained by American experience during the Tunisian Campaign early in 1943, and led to the establishment of individual blood banks in hospitals in the North African theater of operations. This system was maintained in that theater until January, 1944, when, following the arrival of the needed supplies, a central collecting and distributing blood bank was established. This bank, supported by military donors, supplied the needed amounts of whole blood for the remainder of the Italian campaign. Its success, coupled with an awakening realization by the services, of the value of whole blood in the treatment of the wounded, led to the development of a program by the middle of 1944, which provided for the shipment by air of large quantities of blood from the United States to the European and Pacific theaters of operations.

SULFONAMIDES

Despite the fact that much has been said about the value of sulfonamides in the prevention of all types of infection in wounds during the second world war, the results of carefully controlled studies upon this point show that while serious spreading infections could be controlled by the oral administration of sulfonamides in adequate doses, the development of local wound infection was little influenced by the local or systemic use of these drugs.

Penicillin was a valuable adjunct to rational surgical therapy in the wounded. This antibiotic was superior in its effects to the sulfonamides because of its greater activity against staphylococcal infection. It was decidedly less toxic, and because it had to be administered parenterally, there was a reasonable assurance that the wounded soldier would receive it at the required periods. The intelligent use of penicillin permitted wounds to be closed by secondary suture much more regularly and at an earlier time than was possible when sulfonamides were in use for the prophylaxis of infection.

CARE OF THE WOUNDED

The record which has been made in this war by American surgeons in their treatment of their wounded was enviable. To date the record shows that but 4.5 per cent of the wounded have succumbed. This is to be compared with a death rate of 8.26 per cent in wounded American soldiers in the A. E. F. in the first world war, and a 10 per cent death rate which was recorded in wounded German soldiers during the first four years of World War II. This saving of life has been achieved primarily by the skill of American surgeons and their ability to develop rapidly the concepts which were necessary for the intelligent management of the wounded. Few, if any, of the surgeons had ever experienced the flow of gross trauma which faced them when the battle was on and casualties began to pour in. Their conceptions respecting pre-operative, operative and post-

operative treatment had to be altered to fit the conditions under which they had to work. Their intellectual flexibility, their ingenuity at improvisation and their constant attention to detail in the care of the wounded provided a great tribute to the system of medical education which developed these surgeons. Their record was not equalled by any other nation.

IMMUNIZATION

Important advances were made in the prevention and treatment of disease during the war. One of the outstanding advances in the prevention of disease was concerned with the use of tetanus toxoid in the Army. Ramon and his associates [7] had demonstrated the possibility of immunization against tetanus in the nineteen thirties. In the late summer and fall of 1940, the Medical Department of the Army made repeated attempts to impress the War Department General Staff of the value of tetanus toxoid and to introduce its use as a universal practice in the Army. These efforts were rebuffed by the War Department General Staff because of their fear of adverse criticism from anti-vaccination groups if another immunization procedure was added to those already in use. In matters of health, the Medical Department only functions in an *advisory* capacity to the General Staff. In the middle of 1941, after a great deal of pressure had been applied, the General Staff reversed its position and authorized the immunization of all personnel in the Army of the United States with tetanus toxoid. Rarely has an immunization procedure been so effective, there being but three recorded cases of tetanus in the immunized personnel of the Army during the entire war. Only one battle casualty developed tetanus.

Immunization against epidemic typhus fever proved to be very reliable. The value of this procedure has been overshadowed by the later spectacular use of DDT in controlling civilian epidemics of typhus. In the winter and spring of 1942-43, typhus was epidemic in North Africa and there were hundreds of thousands of instances of the disease in the civilian population. Among American Army personnel who had been immunized and re-immunized with the Cox type of typhus vaccine, but two mild cases of the disease were recorded in the first four months of 1943, while during the same period in a comparable group of Allied troops in whom vaccination was not initiated until the end of February, 1943, a total of 43 cases were recorded, with a case fatality rate of roughly 30 per cent.

MALARIA

As a result of the tactical employment of American troops in certain of the most malarious areas in the world, much has been learned by medical officers during the war concerning the suppressive and therapeutic effects of quinacrine. It was found that the original plan of administering 0.2 gram of quinacrine* twice a week was not very effective in suppressing malaria. In certain areas this system of administering the drug for suppressive purposes was followed by acute and at times severe toxic reactions (nausea, vomiting, diarrhea and fever) after the third or fourth dose of the drug had been given. Extensive experimental and field studies upon the pharmacology and suppressive effects of quinacrine which were made possible during the war by the development of a fluorometric method [8] for determining the concentration of the drug in the body fluids and tissues, demonstrated that not only did the administration of 0.1 gram of quinacrine daily produce far fewer acute toxic reactions, but that this dosage, if taken conscientiously, produced a high degree of suppression of malaria produced by plasmodium vivax and a casual prophylactic effect insofar as infections produced by plasmodium falciparum were concerned.

Because of the fact that quinacrine acted only as a suppressive agent against infections produced by plasmodium vivax, extensive investigations were carried out under the auspices of The Board for the Coordination of Malarial Studies. This board was composed of representatives of the Army, Navy, United States Public Health Service, Office of Scientific Research and Development and the National Research Council. In one of the most

* Quinacrine is the pharmacopeial name for atabrine.

7. Ramon, G.: Rev. d'immunol. 5:479, 1939.
8. Brodie, B. B., and Udenfriend, S.: J. Biol. Chem. 151: 299, 1943.

beautifully coordinated programs which marked scientific endeavor during the war, some 14,000 chemical compounds were studied for their antimalarial activities. The pharmacology and toxicology of a large number of these compounds were investigated and about 80 of them showed promise enough to warrant clinical investigation in human malaria. While no true causal prophylactic was discovered, chloroquine, or 7-chloro-(4 diethylamino-1-methylbutylamino) quinoline, was found to be "an effective suppressive when administered no more frequently than once weekly in a well tolerated dose".

The war enormously increased our knowledge of the advantages and shortcomings of quinacrine in the therapy of clinical malaria. Prior to 1942, little was known concerning the pharmacology of quinacrine, and hence, therapy with this drug was entirely on an empirical basis. This was well evidenced by the early recommendation for the use of quinacrine in the treatment of malaria with quinine, quinacrine and plasmochin, in which after two days of quinine therapy, quinacrine in doses of 0.1 gram three times a day for five days was started. With what is now known concerning the rapidity of the execretion of quinine and of the plasmodiacidal concentrations of quinacrine, it is clear that under this system of therapy the malarious patient was relatively under-treated for a period of about 36 hours after the exhibition of quinacrine. Fortunately, the brilliant and rapid development of methods [8] by which the pharmacology of quinacrine could be studied, revolutionized the treatment of malaria with this drug and produced a rational method of treatment. Then it was possible for the first time to demonstrate that quinacrine was superior to quinine in the treatment of malaria. It is also noteworthy that in the course of the investigations which have been alluded to before, and which resulted in the discovery of the antimalarial properties of chloroquine, or 7-chloro-(4-diethylamino-1-methylbutylamino) quinoline, it was found that this drug would cause "an abrupt termination of the clinical attack of *vivax malaria*" and would "cure *falciparum malaria* when administered for only one or two days". Further, more recent investigations tend to show that a member of the 8-aminoquinoline group of compounds, SN 13276, may actually be curative in malaria caused by infection with plasmodium vivax. Thus, at the present time we have two drugs, quinacrine and chloroquine, which will cure malignant tertian malaria, and definite hopes that a curative agent for benign tertian malaria is just in the offing.

9. Science: 102:601, 1945.

ANTI-LEWISITE

Another very interesting development during the war was the discovery of an anti-arsenical, 2, 3, dimercaptopronal [9] to which the name BAL (British Anti-Lewisite) was given. This compound was demonstrated to be an active therapeutic agent against the local and systemic action of certain arsenical war gases and also was found to be of value in the treatment of certain types of arsenical poisonings which occur in civilian populations. It has been shown that the drug is efficacious in treatment of patients suffering from arsenical dermatitis, arsenical encephalitis and in patients who have received overdoses of mapharsen. It may be of some value in treating the blood dyscrasias which may occur in the course of arsenical therapy. It is valueless in the treatment of alleged arsphenamine jaundice. Recent preliminary trials indicate that BAL will be of great value in the treatment of mercurial poisonings.

INSECTICIDES

The war focused the attention of those concerned with the prevention of disease upon the possibilities for developing newer and more effective insecticides and rodenticides. The development of dichlorodiphenyltrichloro-methylmethane (DDT) as a personal and environmental insecticide represents one of the most important advances in preventive medicine during this century. Following the demonstration in the North African theater of operations by Dr. Fred L. Soper and his group of the value of DDT in a dusting powder for delousing unreliable, exotic native populations, the use of such a powder for delousing the population in Naples in the winter of 1943 averted a major civilian outbreak of epidemic typhus fever in

Italy. The application of the experience in mass dusting which was gained in Naples to the displaced persons and prisoners of war in Central Europe after V-E Day, not only cut short existing epidemics of typhus among such individuals, but also prevented extensive outbreaks of the disease all over Europe. The utilization of the residual effects of DDT sprays has revolutionized practices for the control of flies, mosquitoes, and moths in and about dwellings. The value of DDT in the elimination of mosquito larvae has been adequately demonstrated and it seems not unlikely that as a result of this observation great progress may be made in the control of mosquito borne diseases.

CLIMATIC ADJUSTMENTS

Many notable studies were conducted on the physiologic adjustments which man would have to make in order to remain effective or even alive in the environments in which he was placed. Oxygen masks have been developed which permit trained men to fly at sub-stratosphere altitudes. Pressure suits which permit "pull-outs" in high speed dives and tight spirals have been developed. The study of "bends" and "bubble-formation" has contributed much information which is valuable in the selection of certain types of flying personnel, and the prevention of "bends" by preoxygenation. For the first time in our history the science of clothing has been developed with the result that much is now known about the fundamentals of fabrics and their ability to transfer heat and water vapor. Studies of the stresses which the human organism may stand in crash injuries have demonstrated that with proper cockpits or other similar enclosed spaces, the body may withstand crash injury in a degree considered impossible prior to the war. Notable studies were made upon the factors which govern night vision, with the result that practical methods were developed for improving night vision in specialized personnel. Extensive studies were made upon the behavior and acclimatization of man to high and low temperatures. Definite advances have been made in our knowledge of the metabolic changes which occur at extremes of temperature and of the steps which need to be taken to maintain human beings at an effective level under such altered environments. The studies upon the determination of salt and water requirements under such conditions have been especially interesting.

NEUROPSYCHIATRY

A great deal has been added to the sum total of medical knowledge by personnel of the medical and other corps of the armed forces. It was characteristic of the system of medical education with them which made American medical officers all over the world observe, contemplate and then record the various phenomena of disease. Many of these observations are still contained only in official reports, others are in the process of publication, and some will appear only in historical perspective. It can be said, however, that medical officers have contributed notably to the natural history of disease during the war. Their advances in the field of neuropsychiatry were notable. The armed forces were primarily interested in the maintenance of manpower. Their motto was "to keep them fighting or flying" as the case might be. This meant that every effort had to be made to keep men fit, and if for any reason they became ill, to get them back to duty as soon as possible. In the field of neuropsychiatry this meant that relatively little time could be spent on the problems of psychotics because the major effort had to be exerted in the prevention of neuroses and the rehabilitation of neurotics. This direction led neuropsychiatrists initially to develop methods for the early detection and prompt, rapid treatment of neuroses. As a matter of fact, it can be said that all medical officers in the service became conscious of and familiar with the problems of neurotics. This emphasis on the early recognition and treatment of the neuroses led to investigations of the factors which produced combat neuroses, in the hope that methods could be developed for their prevention. Notable contributions were made in this field of military neuropsychiatry. The respective roles of motivation, leadership, morale, length and stress of combat and a number of other factors in the production of combat neuroses were elucidated by military psychiatrists. By the end of the war

these studies had progressed to a point which made it possible to predict with considerable accuracy the amount of stress which the average soldier could stand without cracking up. The appreciation of this knowledge gained by the psychiatrists permitted notable savings of manpower in those commands in which commanding officers had the common sense to appreciate the data supplied to them by their psychiatrists. It has been the personal opinion of the author for several years that traditional psychiatric thought has been too preoccupied with the problems of psychotics, while being neglectful of those of neurotics. It is to be hoped that the gains in knowledge in respect to neuroses which were made during the war will not be lost in the post-war period. It should be recognized that we are living in a time of extreme economic, political and social stresses and strains. It is a time when psychiatrists should devote their major efforts to the application and extension of those principles for the prevention of neuroses which proved valuable during the war to the problem of the neuroses which are constantly and increasingly arising in our civilian existence.

THE AMERICAN MEDICAL OFFICER

Medical officers have clarified the epidemiology, etiology and pathology of homologous serum jaundice and infectious hepatitis, and have extended our knowledge of the clinical course of these diseases. They have contributed notably to the diagnosis, prevention and treatment of epidemic typhus fever. Medical officers have provided much that is new concerning the prevention, suppression, clinical course and treatment of malaria. The natural history of schistosomiasis, "scrub typhus", filariasis, etc., and methods for the prevention and treatment of these diseases have been investigated by medical officers. And, while carrying on these studies, they attended the sick so efficiently that the over-all fatality rate in admissions for illness was less than 0.1 per cent in World War II. This is to be compared with the fatality rate of 1.68 per cent for admissions for illness which was recorded in the first world war, and a case fatality rate of 2.0 per cent for all illness occurring in the Wehrmacht during World War II through February, 1944.

It has been fairly easy to outline some of the advances which have been made in the medical sciences during the war, because they represent specific and tangible additions to knowledge. It is much more difficult to assess definitely the impact of the war upon the professional development of medical officers and upon the education of medical students and doctors. It will be necessary in the consideration of this problem to discuss certain aspects of the practice of medicine in the Army.

Three factors limited the type of medical practice encountered in the Army. These were the initial screening of prospective patients, a process designed to eliminate the unfit; the age group of the patients; and the high incidence of injury in patients admitted to Army hospitals. The practice of medicine was mainly focused upon diagnosis and treatment of infections, psychogenic disturbances, and of battle and other injuries. The ordinary neoplastic, degenerative and metabolic diseases, and many of the common surgical diseases were rarely seen. On the other hand, due to the global character of the war, many physicians in the Armed Forces became thoroughly conversant with malaria, the dysenteries, infectious hepatitis, scrub typhus, schistosomiasis, kala azar, filariasis, dengue, sandfly fever, etc., diseases which in their past experience had appeared as clinical rarities or text book oddities. Surgeons became acquainted with injuries of a type which they had never seen before, and which, let us hope, they will never experience again. Medical officers became alert and at times, one might say, almost allergic to the possibility that psychogenic disturbances might be the basis for the patient's complaints. The practice of preventive medicine became a part of the daily routine of thousands of medical officers, and for many was practically their sole approach to professional duties. Thus, for the period in which they served in the Armed Forces, medical officers. if in contact with patients, engaged in a type of practice which of necessity was specialized, and which was not, with the exception of their experiences in preventive medicine, infectious diseases, gross trauma and with psy-

chogenic disturbances, of a type which normally would serve to fit them for civilian practice.

The organization of the Army is such that many medical officers had little opportunity to enjoy much professional contact with patients during the war. The author has made an analysis of the status of the 2,057 temporary medical officers who were on duty in the Mediterranean theater of operations in Italy on May 2, 1945. Of these officers 997, or 48 per cent, were assigned to battalions, squadrons, regiments, groups, depots, wings or to administrative positions. One thousand and sixty medical officers were assigned to professional duties in hospitals. Twelve hundred and seventy-two, or 60 per cent of this group of medical officers, were captains. Eighty-eight per cent of these captains had been overseas for more than one year and 40 per cent of them had been overseas for two or more years. Forty per cent were more than 34 years of age. Five hundred and thirteen of these captains were rated by the Army as medical or surgical specialists. However, despite their age, training and length of service, these medical officers remained captains. Promotion for them was an impossibility because of the stupid inflexibility of the Tables of Organization of the Army. If a position-vacacany for promotion did not exist, then promotion could not take place.

Despite the attempts which have been made to glamorize the life and work of battalion or regimental medical officers, it is fair to say that theirs was a tough job. In combat units, the medical officers had little more to look forward to than unpleasant living, illness and possible injury or death. The fact that they served uncomplainingly was due to their profound sense of professional responsibility to the men in their units. The epitome of their professional duties in battle was first aid, or the holding of sick call. They were practically cut off from professional contacts and literature. Medical officers in service battalions or squadrons, while not subject as a rule to the same hardships as combat medical officers, nevertheless led very restricted professional lives. Administrators rarely were able to maintain professional contacts. Studies which were made in the Mediterranean theater of operations seemed to indicate that medical officers suffered serious deteriorations in their professional skills if they were separated from the practice of medicine for more than a year. Thus, from the summary that has just been given, it is evident that about half of the medical officers in the Mediterranean theater were assigned to positions in which the chances for professional deterioration or stagnation were great.

It can be said, that as a rule, in hospitals of all types there was at one time or another a chance for the assigned medical officers to practice medicine or surgery. The term "one time or another" was used purposely because the professional training of many medical officers in hospital units was frequently not utilized for long periods of time when their units were in "training" or were "staging". It is not within the scope of this presentation to discuss the wisdom of "training" programs or the problems of "staging". This subject has only been mentioned in order to show that from the professional point of view, medical officers were often inactive and out of touch with patients.

It is recognized that from the educational point of view it is necessary for physicians to follow their patients from the beginning to the end of their illness, if medical and surgical skill is to be developed. It is also true that interruptions of the course of treatment are not beneficial to patients. One of the great, though at times necessary, interferences in the practice of rational medicine or surgery in an overseas theater of operations during the war was the movement of patients from the front to the rear and from one hospital to another. This meant that insofar as the majority of patients was concerned, the medical officer responsible for initial definitive treatment never knew just what happened to his patients. This was especially true of battle casualties. Figures from the Fifth Army indicate that during the campaigns in Italy during 1944, 78 per cent of the wounded were evacuated to the Base Section. Thus, surgeons in the auxiliary surgical groups, and the Field or Evacuation Hospitals who were responsible for the primary surgical therapy of these patients had little personal chance

of knowing whether their initial decisions and actions in respect to therapy were correct. They generally received such information second hand from the base. To a lesser degree, this same state of affairs existed in respect to the sick, with the result that physicians knew little of the eventual disposition of many of their patients. These facts are presented to you to show what war can do to the professional life and development of a doctor.

Despite the difficulties which have been mentioned, the horizon of certain medical officers was enlarged by the war. For the surgeon, experience in wound surgery (if not too long continued) was not only a traditional but also a vital phase of his total training. The early education of a surgeon is in character of an apprenticeship which may lead to a provincial and dogmatic point of view. The sharing and pooling of surgical experience and the contact with other schools of surgical thought which marked the practice of surgery in a properly supervised theater of operations, exerted a broadening influence on the intellectual growth of surgeons. This same was true for internists, although in a lesser degree, because the practice of internal medicine is less subject to dogmatism and lends itself more to the standardization of its technics. The internist benefitted from his exposure to exotic diseases, but his experience with such diseases cannot be considered as being vital in his total development.

It seems proper at this point to consider the fact that more than half of the practicing physicians in this country came under the prolonged control of administrators in the course of their service in the armed forces. This experience came at a time when doctors in this country stood on the threshold of a social structure whose protagonists desired in one way or another to organize the medical profession into groups, rather than to permit it to continue in its individualistic course. A prolonged experience in the armed forces in which administration is definitely (and to be fair, necessarily) in the saddle, can be expected to leave indelible imprints. This seems to be particularly true because the administration embodied those undesirable attributes which are opposed in the peace-time practice of medicine. The reference is of course to those limitations in outlook and perspective which led to the tardy recognition of and inadequate concessions to professional needs.

The impact of this experience with administrators may not be apparent immediately, as this group of doctors is being dispersed and is at present inarticulate. Also, this is essentially a junior group and it is returning to a junior rank in the hierarchy of American medicine. The full effects of this experience and the nature of the lesson learned will be apparent only in the maturity of individuals and in group judgments and actions in the years to come. It may have been fortuitous, as has been said, "for the profession, poised at the 'Crossroads', to have sent a large task force down the road where inefficient administrative control was rampant, and three years later to have it rejoin the main force as seasoned (if disillusioned) troops".

THE WAR AND MEDICAL EDUCATION

The time is not ripe to state with any degree of finality what the impact of the war has been upon the education of medical students in this country during the past four years. However, it seems possible at this time to discuss the effects of the war upon certain aspects of medical education.

The faculties of the schools of medicine in this country were denuded by the armed forces. A survey of the teaching staff of The Johns Hopkins University School of Medicine in 1944 and 1945 shows that roughly 28 per cent of this staff were on leave of absence in the armed or other forces of this country. A further analysis shows that 35 per cent of the members of the "full-time" or the senior teaching staffs were on leave of absence. In addition, seventeen of the members of the staff in the grades of Professor or Associate Professor were on national committees or in consultant capacities having to do with the maintenance of the health of the nation or of the Armed Forces. As most of these committees were active, it meant that much time had to be spent away from normal academic duties. Then, on top of all this, the patient burden both in The Johns Hopkins Hospital and in private practice in Baltimore

increased markedly during the war years. It is obvious from these statements that the net result was, more to do with fewer to do it. This situation was paralleled in all medical schools and hospitals in the country. It is impossible to evaluate the effects of the program for the acceleration of pre-medical and medical education, because it was carried out during a period in which it was impossible to control those other factors which are involved in medical teaching. However, if previous concepts in medical education were correct, then the decrease in the time spent in pre-medical preparation, and the lack of opportunity for individual research or contemplation which marked this program in medical schools, were undesirable features and produced a substandard type of medical education.

The modern medical student finally fits himself for the practice of medicine during his period of residence on the house staff of a hospital. It would appear that our medical educational system has suffered most in respect to the training of interns and residents. To begin with, the majority of medical graduates, if physically fit, received but nine months of training and at the most, twenty-seven months during the war. While intern staffs were not too seriously depleted, assistant-residencies and residencies were cut to the bone. This meant that a markedly increased patient-load was thrown upon intern and resident staffs at a time when such staffs were least prepared to assume such a burden. The result was that the resident staffs of hospitals were primarily concerned with the technics of patient care and with the movement of patients through the hospitals, and there was little time left to them for the study and contemplation of their patients. This, coupled with the diminished number of senior physicians who ordinarily counsel and teach the house staff, meant that the standards for the training of interns and residents fell appreciably during the war. It would seem that this failure in training of interns and residents constitutes the most serious defect which developed in medical education during the war. Three classes of interns have graduated who have had but nine months of training and that under conditions which were distinctly substandard. In addition, because of their age and physical fitness, it is more than likely that when these interns entered the Armed Forces, their assignments were to posts of battalion surgeon or their equivalent. It has been already shown that the opportunities for advancing a physician's processional education is very, very limited in such a position. It is therefore quite clear that a very heavy responsibility rests upon the medical departments of both the Army and the Navy in respect to providing further hospital training for medical officers who have had but nine months of internship. As has been pointed out, experience in the North African and Mediterranean theaters of operations demonstrated beyond question that a period of twelve or more months of field service for medical officers produced a type of professional stagnation for which months of rehabilitation in actual hospital work were required before the confidence and professional skill returned. If this was the experience with medical officers, many of whom had had long years of training, it is not difficult to imagine what may happen in the group which have had only nine to twelve months of hospital training, if they are removed from the practice of medicine for too long a time. It was demonstrated in the North African and Mediterranean theaters that it was possible to prevent the professional stagnation of medical officers by rotating them from the field to hospitals for duty. It is to be hoped for the future of medical practice in this country that the medical departments of the Army and Navy both at home and overseas contemplate a program of this type for the temporary medical officers who will be in service for the next few years. It must not be forgotten that just as great a responsibility for the professional rehabilitation of these men rests upon the civilian profession as upon the medical departments of the armed forces.

Consideration must be given to the possible implications of the recent directive from the Procurement and Assignment Service which dealt with the reconversion of the 9-9-9 program. The aims of this directive are to provide the armed forces (primarily the Army) with the needed numbers of physician replacements for 1946, to increase the number of resi-

dencies which will be available for physician veterans and to lengthen the period of internships to the traditional twelve months. To accomplish these ends, the directive makes all physically fit non-veteran interns and residents liable for service in the armed forces by July, 1946. The immediate intent of this directive is admirable, but it is necessary to consider its possible effects upon research and the practice of medicine in the United States. The high standards of medical practice which have increasingly marked American medicine during the past twenty-five years were not achieved by chance. They were the direct result of a calculated program for the continuous education of the young physician. The selection of the bulk of the young medical men in this country for service in the armed forces interrupts this program, and transfers these individuals to the relatively limited and sterile fields of military medicine, at a time in their careers when their seeds of productivity in medical research normally begin to sprout. It remains to be seen whether these seeds will maintain their vigor or will die in the barren soil in which, by necessity, they frequently must be sown. If their vigor is to be maintained, these young men must be returned to the laboratories and clinics of this country within a reasonable period. Otherwise, the present standards of American medicine will be compromised.

CONCLUSIONS

1. Research and the results achieved therefrom were greatly accelerated during the war in such specialized fields as preventive medicine, the treatment of infections, aviation medicine, the management of surgical emergencies, the control or elimination of insect pests, etc. It would appear that research has languished in the fields of neoplastic disease, endocrinologic disturbances, metabolic diseases and degenerative diseases during the past five years.

2. As far as the continuing professional education of the medical officer was concerned, that the general effect of the war was definitely unfavorable.

3. The impact of a system of medical practice in which administrators were firmly in the saddle has left its imprint on more than half of the active doctors in the United States. It is too early to predict what the final reactions of these doctors will be towards administrative systems of medicine.

4. The medical student's *total* education before entering the Armed Forces has been definitely deficient since 1943.

5. The present policy of making all physically fit medical graduates liable for military service after the completion of a twelve months internship will endanger the existing standards of medical practice in this country, if these young men are held too long in the services.

6. A continuing program of professional rehabilitation must be provided for physician veterans. The medical departments of the Army, Navy, Veterans Administration and civilian medical schools and hospitals share a joint responsibility for the maintenance of this program.

The Johns Hopkins University
School of Medicine

DIABETICS NOW ELIGIBLE FOR LIFE INSURANCE

For the first time it is now possible for a controlled diabetic to obtain life insurance. These policies are available only to men and women under the age of 60 who are able, in spite of their diabetes, to carry on their regular work and who are under medical supervision. Only one company now writes this type of policy. The rates are $10. a thousand more than ordinary life policies. These policies are not issued unless the diabetic indicates that he is adhering carefully to his regime and conscientiously cooperating with the doctor. Further details may be obtained from the Medical Director of the Medical Service Administration of New Jersey at 31 Clinton St., Newark.

THE ELECTRO-ENCEPHALOGRAM IN MEDICAL PRACTICE *

Morton M. Stern, M.D., Newark, N. J.

The electro-encephalogram is now ready to leave the laboratory, and move into the practical fields of medicine. Because of its intimate relationship with the brain, it is of particular interest not only to the neuropsychiatrist but also to the internist and general practitioner who want to know how the electro-encephalogram may be used as an aid in private and hospital practice.

The electro-encephalogram was first put on a sound basis by Hans Berger in 1929. Earlier, Caton had discovered in 1874 that animal brains gave off electric potentials. In 1918 Neminski made records of these cortical potentials, and described two sets of frequencies. Then followed Berger's work which, first greeted with skepticism, was confirmed by Adrian and Matthews in 1934, and the race for progress started.

DESIGNATION OF RHYTHMS

An electro-encephalogram is a record of electrical activity given off by the cerebral cortex. The electrical potentials are picked up through the skull and scalp by small electrodes applied to the scalp. The potentials are directed into an amplifying system, and then are traced by calibrated pens on paper moving at a standard rate of speed. In this way a record is obtained of the frequency, amplitude, and wave form of the electrical potentials or rhythms given out by the brain. The types of rhythms are designated alpha, beta, gamma, and delta. Alpha rhythm is a normal pacing found most commonly over the occipital lobes when the eyes are closed, and characterized by a frequency ranging from 8½ to 12½ cycles per second, and an amplitude of 20 to 60 millivolts. Beta rhythm is found most commonly over the frontal areas, and has a frequency between 18 and 32 cycles per second, and an amplitude of below 20 millivolts. Gamma rhythm is very rapid and of low amplitude; its significance is not known. Delta is a high amplitude rhythm, slower than alpha. It is always abnormal when present in patients above the age of 13. Below 13, the presence of delta waves (in an amount varying roughly inversely with the age) is being gradually accepted as normal. The rhythms of homologous areas are generally synchronous, and of nearly equal amplitude in the normal individual. Marked variations in frequency and amplitude are pathologic. Very fast high amplitude waves, called spikes, are also pathologic, and when combined in a regular alternating sequence with slow waves, this is considered pathognomonic of petit mal epilepsy.

MENTAL DISORDERS

The recordings have found their greatest use in the diagnosis of epilepsy, and in the localization of brain tumors and brain injuries. The question arises, "Since the electro-encephalogram is a record of brain activity, can it be used in the diagnosis of mental states?" Attempts have been made in this direction, but results to date are inconclusive. There is some evidence of faster activity in the schizophrenias and depressive states, but very often, in these diseases, the rhythm is no different from that of so-called normals; in the paranoid reaction types, a stable alpha rhythm is the rule. In the constitutional psychopathies, and in behavior problems, several observers have found slow wave abnormality, but this problem has as yet not been completely evaluated.

FAINTING SPELLS

The electro-encephalogram, therefore, can make no claims of writing out the diagnosis of mental disease merely by the scratch marks of its pens. Nevertheless, its contributions to medical practice are solid and substantial. The physician is often confronted by vague and conflicting symptoms such as headache, unsteadiness, lack of coordination, dizziness, fainting, alleged "fits", tremors, impaired vision, vomiting, lethargy, drowsiness, and peculiar behavior. Most of them he can resolve as being

* Read June 5, 1946, at Greystone Park before joint meeting of the staffs of the New Jersey State Hospitals at Greystone Park, Marlboro and Trenton and the Village for Epileptics at Skillman.

either functional or organic. A few may puzzle him, and he would like help. It is here that the electro-encephalogram may be of great help, since an abnormal tracing points to organic disease.

Of all these symptoms, those classified as "fits" may be the most troublesome. The physician generally sees the patient alleged to have "fits" after he has recovered from the seizure. He finds no organic signs to account for the symptoms, and can get only an unreliable account of the "fit" itself from emotionally involved witnesses. He wonders whether the patient had a grand mal or psychomotor epileptic fit or a catatonic or hysterical seizure; and he is further confused if a history of peculiar behavior is given. If an electro-encephalographic tracing is made, the finding of a generalized high amplitude slow wave abnormality favors epilepsy, whereas a normal record suggests a functional diagnosis.

Allied to this is the problem of fainting. Is it a hysterical symptom, or a petit mal attack or an aborted grand mal seizure? Again an abnormal record indicates epilepsy and a normal record functional disease. Moreover, if a spike and wave pattern is present, the diagnosis is almost certainly petit mal epilepsy.

BRAIN TUMORS

Headaches, dizziness, vomiting, sleepiness and lethargy occur as frequently in organic disease of the brain as in psychoneurosis; and a psychoneurotic-like syndrome is often found in brain tumor. In these cases, especially frontal tumors, the mental picture may mimic dementia praecox, depression or psychoneurosis, and may be the only positive finding without any localizing organic signs. The electro-encephalogram frequently shows a definite focus of abnormality limited to one circumscribed area of the brain, and is of great value in indicating the proper management of the case. On the other hand, it is important to remember that a normal record does not rule out a neoplasm.

HEAD INJURY

In head injuries (which often are characterized by neurotic-like syndromes) the electro-encephalogram is useful in determining the presence and persistence of cerebral damage. Soon after injury, slow waves may be present over the injured area. As the symptoms improve, the electro-encephalogram tends to become more normal and is often in advance of the clinical improvement. Among patients who do not improve clinically, the electro-encephalogram tends to remain abnormal. If the record is persistently abnormal after a period of one year following injury, the patient may be considered a candidate for a post-traumatic epilepsy. In subdural hemotoma, the electro-encephalogram reveals a decrease or absence of alpha rhythm over the involved area, and slow wave abnormality at the edges of the area. In patients who fail to show clinical improvement in the presence of electro-encephalographic improvement, the physician may suspect the beginning of a neurotic process. Hence, with the electro-encephalogram, one can determine not only the presence of a cerebral injury, but (by means of serial records) can prognosticate the course of the process.

OTHER USES

Aside from the conditions already described, the electro-encephalogram has been little utilized. In infectious and degenerative diseases, such as meningitis, encephalitis, general paresis, hydrocephalus, senile dementia, and vascular accidents, the record is frequently abnormal, but reliable correlations have not yet been made.

The electro-encephalogram may be used in the differentiation of hysterical from true blindness. Both types usually show good alpha rhythm. In the blind person, blinking of the eyes has little effect on the alpha rhythm, whereas in the person with normal vision, including the hysteric, blinking causes the alpha rhythm to disappear.

CONCLUSION

The electro-encephalogram is of great value in the diagnosis of epilepsy, the localization of brain tumors, and in the localization and prognosis of head injuries. Tracings should be taken in patients with headache, dizziness, fainting spells, convulsions, drowsiness, and other symptoms pointing to cerebral dysfunc-

tion. The results of an electro-encephalogram should be used cautiously in the diagnosis of infectious and degenerative brain disease, constitutional psychopathy, and behavior disorder. Although a normal record tends to indicate a normal state, it may still be found in the presence of an underlying disease process. Therefore, it must be remembered, that it is the abnormal record which is of greatest significance to the physician.

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A list of 25 references is included in author's reprints.

VACCINATION BY ACCIDENT

Maurice J. Leon, M.D., Montclair, N. J.

A 16-year-old boy was complaining of general malaise, fever and a sore on the left wrist. Physical examination was negative except for the following: temperature 101; pulse 90; large tender node in the left axilla; and a small papular lesion on the flexor surface of the left wrist. The lesion was circular and rested on a large erythematous base. The edges were pearly white, smooth and raised. The center of the lesion was depressed and covered with a brawny scale.

The patient had been wrestling with another boy eight days prior to the visit and had suffered a finger-nail scratch on his left wrist. Three days later, a papule appeared in the area which rapidly enlarged to the lesion described above. The playmate had been vaccinated eight days before the scratch occurred. The vaccination went on to healing leaving a typical scar.

This case is reported because of its unusual interest and because of the difficulty that may be encountered in diagnosing such a lesion.

183 Grove Street

OVARIAN HEMORRHAGE

Intra-abdominal hemorrhage from the ovary is not rare, but only occasionally are the symptoms severe enough to demand surgical intervention. In these cases differentiation from appendicitis or ectopic pregnancy may be difficult. Ovarian hemorrhage is responsible for symptoms in 1% of patients operated upon for appendicitis. Sauramo bases a diagnosis of hemorrhage on : (1) previously normal menstrual periods, (2) sudden onset of symptoms, (3) normal temperature with rapid heart beat, (4) absence of uterine hemorrhage, and (5) absence of inflammatory changes in the internal genitalia. Pain may resemble that of interrupted extra-uterine pregnancy or fluid in the peritoneal cavity.

Ovarian hemorrhages usually occur between the ages of twenty and thirty-five; most frequently during the corpus luteum phase of the menstrual cycle; 10% are in virgins. Hemorrhage not associated with pregnancy may be due to rupture of a follicle, follicular cyst, corpus luteum or cyst in the corpus luteum. Apoplexy of perifollicular stroma may be responsible in some instances. Endocrine disturbance or inflammatory phenomena may be the inciting factors. Surgical treatment of ovarian hemorrhage should be the minimum required. Circular ligature, resection, or salpingo-oophorectomy is the usual procedure.—Act. Obst. Scandinav. 26:105 (1946).

SYSTEMIC MEDICATION BY RECTAL SUPPOSITORY

SIDNEY FRIEDENBERG, M.D., Camden, N. J.

Too many physicians fail to make adequate use of the rectal mucosa as an absorbing medium. Yet when parenteral medication is required, the rectal suppository is ideal for the untrained hand. Indeed, its use in recurrent severe attacks of pain or dyspnea may be life saving. Absorption is more certain and rejection less likely than by the oral route.

At some stage in any of the following conditions the physician will find the prescription of a rectal suppository containing the necessary ingredients useful: bronchial asthma, paroxysmal cardiac dyspnea, coronary thrombosis, gastro-intestinal disease with nausea and vomiting (such as an acute exacerbation of chronic cholecystitis), the abdominal crises of tabes, severe spastic colitis, and intercostal neuralgia.

In disease where the emotional factor plays a major role, the hypodermic injection had best be avoided and often oral medication is impossible by reason of esophageal spasm or nausea. A sedative incorporated in a rectal suppository is an excellent method of treatment for the neurotic patient who awakens in the dead of night with the fear of death upon him, for the patient with hysteria, and for the young woman with repeated attacks of nocturnal paroxysmal tachycardia.

Since large amounts of drugs are used in rectal suppositories, the diagnosis must be certain and the patient reliable, although the possibility of overdosage with the suppository is much less likely than by the oral route.

Local disease of the rectum is not a contraindication to the use of the suppository. A possible exception is a suppository containing aminophyllin which occasionally may prove irritating.

The technic of making the suppository may be left to the pharmacist. Sufficient to note that oleum theobromatis (cocoa butter) is a satisfactory base for any active ingredient. The pharmacist may find that the addition of a small amount of a water-absorbing base such as unguentum hydrophilic (NJF) or aquaphor may be desirable.

Caution the patient to keep the suppositories in the refrigerator. Unlike bananas, they keep very well there.

To minimize rectal irritation, ethyl aminobenzoate and bismuth subnitrate may be incorporated. Ephedrine sulfate may interfere with absorption.

For *bronchial asthma,* a useful suppository is one containing 0.2 to 0.3 grammes (3 to 6 grains) of aminophylline, to which may be added about half as much sodium pentobarbital.

For *paroxysmal cardiac dyspnea,* the suppository could contain from 0.015 to 0.03 grammes (¼ to ½ grain) of morphine sulfate combined with a milligramme (grains 1/60) of atropine sulfate. Aminophylline, 0.2 grammes (3 grains) may be added.

In *congestive heart failure with edema,* I have found the salyrgan-theophyllin suppository (Winthrop) and the mercuzanthin suppository (Campbell) useful.

In *coronary thrombosis, renal colic* or painful *cholecystitis* relief is often afforded by a suppository containing the morphine and atropine combination suggested above for cardiac dyspnea.

The following case report illustrates the value of the rectal suppository in the treatment of heart disease.

W. K., a 55-year-old male, was seen in November, 1945, complaining of shortness of breath. His blood pressure was 240/130 and congestive heart failure was imminent. He was ordered to bed and digitalized. He developed frequent attacks of nocturnal paroxysmal dyspnea. The morphine-atropine rectal suppository was prescribed and consistently afforded him relief. Edema of the legs then occurred, and salyrgan-theophyllin tablets were administered orally. As he vomited these, the same ingredients were prepared in a rectal suppository. Results were good. He inserts a suppository about every ten days, and the resultant rectal irritation is brief and disappears in a day or two. The medication has successfully controlled edema. I believe that the two rectal suppositories in this case were life saving medications.

2290 Alabama Road

RUPTURE OF AORTA DURING DIABETIC ACIDOSIS

REPORT OF A CASE

Everett O. Bauman, M.D., Newark, N. J.

In a search of the literature no reports have been found of spontaneous rupture of the aorta during diabetic acidosis. Spontaneous incomplete rupture of the aorta is a relative rarity in itself. Of the theories of etiology one may be discussed pertinently in connection with diabetic acidosis. Medionecrosis aortae idiopathica cystica, Erdheim's lesion, of the vasa vasorum causes a weakening of the medial coat of the aorta and predisposes it to rupture. This lesion has either not been sought or remains undescribed in diabetics, among the other types of arteriosclerosis commonly associated with this condition. The other considered etiology of incomplete rupture of the aorta is general arterial hypoplasia. Perry * mentions predisposition of the proximal portion of the ascending aorta to a hypoplasia which may or may not be generalized.

In the case reported herewith none of the common arterial lesions were noted and hypertension was not present, although it could have been masked by the accompanying acidosis.

CASE REPORT

A 24-year-old white female was admitted to the Metabolic Service of the Newark City Hospital on January 26. The patient had been diabetic for only two months. The family and past personal history have no bearing on the present illness.

On admission the patient was drowsy but responsive. She had the classical picture of air hunger, acetone odor to the breath and dry tongue. She was only fairly well nourished and developed. The pharynx was slightly injected, the lungs were clear and the heart sounds were regular though rapid. There were no signs of enlargement of the heart, nor were any bruits heard. Temperature was 98, pulse 120 and respirations 34.

The urine on admission showed four plus sugar and four plus acetone. Diacetic acid was present. The blood sugar was 335 milligrams per 100 cubic centimeters.

The patient was given 5 per cent glucose in normal saline intravenously at the rate of 60 drops a minute. Thirty units of insulin were injected subcutaneously every half hour; and as she began to respond, the insulin was reduced to forty units every two hours.

Six hours after admission the patient appeared much improved, as evidenced by her conversation with the nurse and retention of water by mouth. Urinary acetone dropped to one plus and the diacetic acid disappeared. The sugar was still four plus.

At about this time she complained of severe tightness in the chest, accompanied by nausea and great difficulty in respiration. The pulse was full and bounding, but the respiration became suddenly extremely labored: a true dyspnea rather than hyperpnea. The carbon dioxide at this time was found to be 38. Plasma acetone was still found although the urine showed only a trace; and with four plus sugar still present in the urine, hypoglycemia was considered unlikely, inasmuch as the bladder had been emptied at regular hourly intervals. Physical examination of the chest disclosed impaired resonance and breath sounds over the right lower lobe, suggesting, with the clinical picture, either atelectasis or infarction.

The patient received 0.032 gms. (½ grain) of papaverine intravenously with no response. Because of the restlessness and increasing cyanosis, oxygen was administered by tent technic. Two cubic centimeters (30 minims) of paraldehyde were injected intravenously, because of the extreme thrashing about. The patient died two and a half hours later.

Autopsy showed two small perforating lesions of the aortic arch with clot formation over the adventitia of the aorta. There was only a small amount of blood tinged fluid in the pericardium. The right lower lobe of the lung was atelectatic for no anatomically demonstrable reason. There was general hypoplasia of the aorta, and no endothelial sclerosis was found.

* Perry, Thomas M.: Incomplete Rupture of the Aorta. *Arch. Int. Med.*, 70:689 (Nov. 1942).

862 South Thirteenth Street

STATE ACTIVITIES

SOCIETY MEMBERSHIP RATIOS

More than 85 per cent of the practitioners of New Jersey belong to The Medical Society. This is one of the highest ratios in the country. Compare it for example with Connecticut where 75 per cent, and New York where 68 per cent of the eligible doctors belong to the state medical society. However, within New Jersey there is considerable variation. In one county, only 65 per cent of the physicians are identified with organized medicine, while in another, the figure is actually 100 per cent. The following table shows the proportion of the physicians in each county who on November 12, 1946, belonged to the medical society. Arrangement is by rank within this ratio.

Rank	County	Ratio	M.D.'s in County	Society Members
1	Passaic	100%	449	449
2	Middlesex	94%	221	208
3	Mercer	92%	303	279
4	Essex	92%	1501	1380
5	Cumberland	85½%	76	65
6	Union	85%	486	412
7	Sussex	83%	36	30
8	Morris	82%	177	144
9	Somerset	81½%	91	74
10	Salem	80½%	36	29
11	Atlantic	80%	181	145
12	Camden	80%	274	219
13	Hudson	78%	720	557
14	Warren	77%	43	33
15	Burlington	74%	93	69
16	Gloucester	73½%	68	50
17	Bergen	73%	489	357
18	Monmouth	72%	228	164
19	Cape May	72%	46	33
20	Hunterdon	71%	41	29
21	Ocean	65%	51	33
	THE STATE	85%	5610	4759

THE WORKMEN'S COMPENSATION ACT

HENRY A. BRODKIN, M.D., Newark, N. J.
Chief Medical Director, Department of Labor, State of New Jersey

In reading the reports of the Chairmen of the Committees on Industrial Health and Hygiene and Workmen's Compensation in the May 1946 JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY, one is impressed with the importance of the problems as they affect every practitioner of medicine. How much thought does the general practitioner give to these problems which affect him financially, medically and socially?

In 1945, the Workmen's Compensation Bureau received reports of 159,591 industrial accidents. Of this total, 49,515 were compensable. Millions of dollars are paid to physicians as a result of the Workmen's Compensation Act and it is amazing to see how few doctors are acquainted with the Act or its administration. The practitioner should be interested in this problem for many reasons. At a cost to the taxpayer, the state of New Jersey operates courts, employs Deputy Commissioners, referees, doctors and clerical personnel to administer this law. In 1945, more than 38,000 claims were settled by direct agreement or as the result of informal hearing and almost 12,000 claims were either settled or litigated at formal hearings, such litigation resulting in awards.

The Workmen's Compensation Act is one of the most progressive examples of social legislation on our statute books. Prior to the enactment of this law, an injured workman had to bring suit in civil court against his employer and could recover damages only if he proved the employer negligent. Even if negligence were proved, the employer before the present Compensation Law, had available to him the following defenses:

1. The principle that the employee assumed the risk of the particular accident as part of the danger inherent in his employment.
2. Recovery was denied when the accident was caused by the negligence of a fellow employee.
3. Recovery was denied when the employee was also negligent.

The present Workmen's Compensation Law did away with these defenses and now provides adequate protection for the workman and his family. In the past year, it has been further liberalized to give even greater benefits for compensable injuries. The advent of the "one percent second-injury fund" has served both to the advantage of the workman and his employer.

Is the doctor playing his part in the just administration of this law? From my observation, he definitely is not. In the first place, he is not acquainted with the law. Secondly, when called upon to give a report or produce a record, he comes to the court unprepared and too often relies on his memory. Every doctor should be impressed with the value of placing in his record, the answers to HOW, WHEN AND WHERE in relation to the accident, together with a description of all the injuries. An injustice is done to the workman when his case is heard and his doctor testifies vaguely and indefinitely from memory about an accident that happened six months or a year ago. I have often seen a doctor made uncomfortable in the witness chair under the interrogations of an attorney, because he had no record. He leaves the court disgruntled and ill-disposed toward everything and everybody concerned with compensation, when the fault is entirely his own. A doctor is required only to testify to the facts of the case as he knows them, and he must be prepared to know them from a well kept record. He owes this to his patient and to the dignity and reputation of his profession.

Several years ago Dr. William K. Harryman, Chairman of the State Committee on Workmen's Compensation, made an abstract of the New Jersey Workmen's Compensation Law. It would be valuable to have this published in the JOURNAL (with the changes since the abstract was prepared), particularly for men who have returned from service. Medical societies can render a great service if they acquaint members of the profession with the rules and administration of the Workmen's Compensation Act.

The Commissioner of Labor and the staff of the Workmen's Compensation Bureau are now committed to the principle of not making doctors wait and will take their testimony promptly and courteously when their presence is made known. The Commissioner of Labor and his staff want to encourage the presentation of the best medical testimony by the treating physicians and qualified specialists. Constructive criticism on the part of the profession will be welcomed. It is time that the medical profession should attempt to make its proper contribution to the administration of social legislation.

REPORTS OF BARBITURATE POISONING

During 1945 twenty-nine residents of New Jersey died of an overdose of barbiturate. Probably there were additional deaths due to this cause which were never so reported. The Department of Health and the Board of Pharmacy are now making a survey of the sources of the drugs responsible for barbiturate deaths and the cooperation of all physicians is solicited. Any practitioner who has cognizance of a death or severe narcosis induced by barbiturates or opiates is asked to write, telegraph or telephone the State Department of Health, State House, Trenton 7, N. J. (telephone extension 228, Trenton 2-2131), or the Board of Pharmacy at 28 West State Street, Trenton 8 (telephone extension 546, Trenton 2-2131).

MEDICAL-SURGICAL PLAN WINS SEAL OF ACCEPTANCE

The Council on Medical Service of the American Medical Association has examined 84 voluntary prepayment medical care plans now functioning throughout the country. Only 27 of these have been awarded the Council's "Seal of Acceptance". We are pleased to announce that the Medical-Surgical Plan of New Jersey is included in the roster of acceptable projects.

The officers of the acceptable plans have formed an organization known as Associated Medical Care Plans. At its first meeting in Chicago in October national officers were elected. Dr. L. A. Schriver of Cincinnati was named its president and our own Dr. Scott of Newark was elected national treasurer.

MILITARY CITATIONS TO NEW JERSEY DOCTORS

From present records, it appears that citations were awarded to more than sixty New Jersey physicians during the recent war. The list which follows is a preliminary one and the Editor will welcome information as to errors and additions.

ALBANO, Frank, Newark ..... Bronze Star
ANNITO, John, Jersey City .....Legion of Merit
BARKHORN, Charles, Newark .....Commendation
BAUMAN, Richard, Newark ..... Air Medal
BOOKRAJIAN, Edward, No. Bergen..Bronze Star
BOYSEN, Theophilus, Egg Harbor... Bronze Star
*BOYT, Theodore, New Brunswick...Purple Heart
BURNETT, Lawrence, Newark ..... Bronze Star
CALVERT, William, West Orange..Soldier's Medal
CAPPIELLO, William, Newark.....Bronze Star
*CRANKSHAW, Orrin, Summit.....Bronze Star
D'ADDARIO, Anthony, Newark..... Bronze Star
DEFUSCO, Gaetano, Jersey City..Legion of Merit
DEL BAGLIVO, M. G., Secaucus.....Bronze Star
DURR, Walter, Teaneck.....Bronze Star
EAST, Isaac, Jamesburg.....Bronze Star
EDLKRAUT, Edward, Passaic.....Soldier's Medal
FISCHBEIN, Martin, Irvington.....Bronze Star
FORCE, Berwyn, Clifton.....Commendation
FURST, William, Newark.....Bronze Star
GIARDINA, V. J., Newark.....Bronze Star
GLAZIER, Jesse, Newark.....Bronze Star
GLYNN, S. Robert, Newark.....Bronze Star
GROSS, Irving, Verona.....Bronze Star
*HACKETT, Edward, Westfield....Dist. Serv. Cross
HALEY, Paul, Newark.....Bronze Star
HAGMAN, Frank, Kearny.....Bronze Star
HARBESON, James, Camden.....Silver Star
HOOD, George, Camden.....Bronze Star
IMHOFF, Robert, Moorestown.....Bronze Star
JEHL, Joseph, Clifton.....Bronze Star
KLEIN, Edward, Newark.....Legion of Merit
KORALENK, A. H., Newark.....Bronze Star
LAMBERTSON, C., Scotch Plains..Legion of Merit
LEPORE, John, Newark.....Bronze Star
MAFFEO, Carl, Newark.....Silver Star
MAGEE, William, Hoboken.....Bronze Star
McART, James, South Orange.....Legion of Merit
McLAUGHLIN, John, Bayonne.....Bronze Star
MEYERS, Francis, Paterson.....Commendation
MOON, Dabney, Plainfield.....Air Medal
MULFORD, William, Riverton.....Bronze Star
NELSON, Francis, Plainfield.....Silver Star
OGRADY, Michael, Nutley.....Bronze Star
ORRIS, Harold, Newark.....Legion of Merit
PATTI, Frank, Leonia.....Legion of Merit
PENCHANSKY, Samuel, Bayonne.....Bronze Star
POHOWSKY, Alex, Hackensack.....Silver Star
PUPEK, Bernard, Arlington.....Legion of Merit
REINHARD, Louis, Atlantic City.....Bronze Star
ROWELL, Forrest, Jersey City.....Bronze Star
SCHAPIRO, Morris, Bayonne.....Silver Star
SHAPIRO, Edward, Bayonne.....Silver Star
SCHWAB, G., Union City....Silver Star, Clusters
SMITH, Alan, East Orange.....Bronze Star
SORDILL, Anthony, Westfield.Silver Star, Clusters
SPRAGUE, Grover, Ramsey..Presidential Citation
TAFT, Herman, North Bergen.....Bronze Star
TIMBERLAKE, Baxter, Atlantic City....Air Medal
UTKEWICZ, Edmond, Jersey City....Purple Heart
*WILDMANN, George, Trenton.....Purple Heart
WILKINS, Stanley, Red Bank.....Bronze Star
WILLNER, Milton, Newark.....Bronze Star
WIREN, William, Bayonne.....Bronze Star

* Asterisk indicates officers who died while in service, were killed in action, or received citation posthumously.

THE NEGRO PHYSICIAN AND THE DISTRIBUTION OF MEDICAL CARE*

Benoit C. Isaac, M.D., Orange, N. J.

The founders of the New Jersey State Medical Association realized that as an ethnic group, pursuing our livelihood in this important profession, we have to keep abreast of both scientific advances in medicine and the social and economic factors that influence the rendering and distribution of medical care.

There is no occasion here for me to mention the mutitude of inequalities which the Negro doctor must bear, more or less, in various parts of the state and nation. It must be acknowledged that in New Jersey the physicians of our group fare better than in some parts of the country, but this is scarcely ground for complacency. And we recognize an unevenness in our lot in the several parts of our own state. Those of us who fare well have a moral obligation towards those who face more severe handicaps in other corners of the state. Let it not be forgotten, however much we want to think otherwise, that the American mind is conditioned to black and white; whatever affects one Negro affects all. The spirit of acceptance and equality is not divisible into geographic compartments.

That the Negro physician needs better facilities to practice medicine is obvious. That one doctor, no matter how satisfactory his status and how good his intentions, cannot single-handed secure these facilities should be equally obvious. It is through organization, and only through organization that we can fight for these better facilities. And the New Jersey State Medical Association is the organization

* This is an abstract of Dr. Isaac's address, October 9, 1946, on the occasion of his election to the presidency of the New Jersey State Medical Association. The Association is the professional organization of Negro physicians in New Jersey.

to lead the group struggle and to support all individual members in their own efforts towards this goal. This is of paramount importance at the present time because:

(1) With the increasing popularity of hospital insurance, more and more patients will demand treatment in hospitals. If the Negro doctor is not on the staff of a hospital in his own community, the patients will find their way to doctors who are.

(2) Community plans for medical care are springing up everywhere. There is the Medical-Surgical Plan, the Medical Service Administration, the Veterans Care Plan, the City of Newark Indigent Plan, the Farm Security Plan, and more to come. Patients who are beneficiaries of these projects have the right to demand good medical care—which implies access to the facilities of modern medicine. Officials who supervise these projects properly insist that the participating doctors practice twentieth century medicine. If the Negro physician is not to be excluded, he must have at his disposal the tools and institutions of modern medicine.

(3) Socialized medicine may be with us some day . When that happens there will be a gearing together of hospitals, specialists and general practitioners. With a Negro doctor on the staff of a hospital, his chances for integration will be far better than if he were on the outside looking in.

Socialized medicine, let us face it, is a cloud —an ugly cloud in my opinion—but a very real cloud which has been hanging over the heads of American doctors for some time. Alert men and women of the medical profession are apprehensive about it. Should it come, our lot as Negro physicians would be even more precarious, because we know that the medical agencies charged with the job of distributing care under such a system, would consider the Negro professional group last of all. If socialized medicine does come, an equitable and equal integration of the Negro doctors in the state would be essential to our professional survival. And the New Jersey State Medical Association is the only effective medium through which such integration could be accomplished.

You are deluged with literature about health insurance and socialized medicine. How much information, however, do you get on how such projects would affect the Negro physician? None. The State Medical Association must, and will, assume the responsibility of finding the answers to these questions.

Your Association has taken the initiative in numerous activities. We have facilitated the inclusion of Negro doctors in Governor Edge's Commission on Postwar Planning. We spearheaded the appointment of Dr. Stewart to the State Department of Health. We were instrumental in effecting the recognition by The Medical Society of New Jersey of the need of Negro physicians for staff appointments.

So fluid is the state of medical knowledge that the doctor must always be going to school. Graduate courses are essential for the general practitioner, no matter how taxing of time, money and energy attendance at such courses may be. Let it never be said that the Negro physician has failed to keep pace with medical knowledge. Fortunately educational facilities are now being brought to our very door steps. The Medical Society of New Jersey has arranged a well-planned graduate course, starting next year in the Camden area. The Essex County Medical Society has an ambitious graduate educational program centering around the Urban Division of Seton Hall in Newark. New Brunswick, seat of Rutgers University, is another focus of advanced medical education. Several of the specialty societies are operating graduate courses. The metropolises of Philadelphia and New York, both adjacent to our state, are dynamos of scientific education. And the section meetings of the Academy of Medicine and of The Medical Society of New Jersey are compact graduate courses. Your Association urges every Negro doctor to participate in one or more of these courses as often as he can.

In summary I appeal to all Negro physicians in New Jersey to join and support our State Medical Association so that we may continue to carry out our function of keeping you abreast of scientific progress, so that we may aid you in your efforts to secure the staff appointments you deserve, so that we may keep you apprised of trends in medical economics and so that we may coordinate our group with the professional and lay community of New Jersey.

NO SCIENTIFIC TEST HAS EVER BEEN DEvised for determining racial background by an examination of the blood.—(Science Service)

WHERE THE STANDARD OF LIVING IS LOW, tuberculosis is high. In no way is poverty more tragic in its relation to disease than in tuberculosis. —Charles R. Reynolds, M.D.

HUNTERDON COUNTY: THE FIRST CENTURY AND A QUARTER

BARCLAY S. FUHRMANN, M.D.

The history of the Hunterdon County Component Medical Society is the story of two men: John Blane and Obadiah Sproul.

From the reorganization in 1846 until 1924 one or the other of these gentlemen was present at nearly every meeting. Dr. Blane, held every office within the gift of his fellow members, and following the compilation of a history which was published by the society in 1872, he was made historian, a position he held until his death in 1885. Dr. Sproul, was elected secretary in 1871, which position he held until ill health caused his retirement in 1924. During this period he found time, notwithstanding a very large practice, to spend several years in the offices of the State Society serving as its president.

The minutes of the annual meeting of The Medical Society of New Jersey held in New Brunswick in May, 1821, contain the following item:

"On application for authority to form a Medical Society in the County of Hunterdon:

Resolved, That Nicholas Belville, John McKelway, James T. Clark, Joseph Phillips, William Johnson, Henry Poole, William P. Clark, John Bowne, William Geary, Henry S. Harris, John A. Kendry, Henry H. Schanck and E. Porter be authorized to meet at Flemington on the 2nd Tuesday of June next, at 10 o'clock a. m., and there to organize a District Medical Society, according to the act of incorporation, and the recording secretary furnish, when organized, the said society with twenty-five copies of the By-Laws of this Society."

Agreeably to the foregoing authority ten of those named, appeared and took their seats in a meeting held in Flemington on the 12th day of June 1821, and elected the following officers: Nicholas Belville, President; William Johnson, Vice-President; Henry B. Poole, Secretary; John Bowne, Treasurer.

At this same meeting seven new members were accepted making a total of nineteen.

The organization was prosperous from its beginning, and appears to have been well received by its six sister county societies.

The new group was cordially welcomed by the State Society. Indeed the very next year, one of its members, Henry B. Poole, was elected their third vice-president, and the following year William Johnson, of Whitehouse, was elected third vice-president. His name erroneously appears in the records as Jacob Johnson.

The organization continued active until 1828 when (for no apparent reason) as Dr. Blane puts it, the society was "bushed", much to his chagrin. In 1835 under the leadership of Dr. Blane, attempt was made to organize anew, and such authority was again granted. In 1836 the society was reorganized, elected officers and forwarded the proper credentials to the recording secretary of the State Society who referred them to the standing committee, which as far as can be ascertained, never reported on the matter. As Dr. Blane states it, "Our society took the shady bush again, and in defiance of all intercessions and notices to meet, remained so until 1846." In that same year a new charter was asked for and granted. Interest was dynamized by the enthusiasm of Dr. John Blane. From this time until his death, he is mentioned in some capacity in the minutes of almost every meeting: he is reading an essay or a history, or he is put on a committee, or he makes some remarks which were well received. In all it seems to have been his society.

Dr. Sproul was elected a member in 1867. His name next appears in the minutes in 1869 when he was elected delegate to the State Society. He continued as a delegate off and on until he became an officer in that body. In 1871 he was elected secretary of the local society a position which he held for almost fifty-four years. During this time at the close of the roll-call appear these two words, "and Sproul". His minutes, written in long hand, are a pleasure to peruse and notwithstanding the reputation held by physicians as poor penmen, are legible and easy to read.

On the fiftieth aniversary of his graduation from the University of Pennsylvania (which was also the forty-sixth year of his service as secretary of the Hunterdon County Medical Society) he was presented with a loving cup suitably inscribed. Dr. Sproul in responding to the remarks made by Dr. Salmon assured the members that his work for the society had been a labor of love.

After his death a tablet in his memory was unveiled in the auditorium of the New Jersey State Sanitorium at Glen Gardner, which institution was undoubtedly located in Hunterdon County, because of his efforts.

At various times, The Medical Society of New Jersey has come to Hunterdon County for officers and four Hunterdonians have served as presidents of the State Society. These

were: Samuel Lilly, John Blane, George H. Larrison and Obidiah Herbert Sproul.

The one hundredth anniversary of the society was celebrated on June 21, 1921, by a special meeting held in Flemington followed by a banquet.

At that time Dr. David C. English made the principal address, Dr. Sproul read a history of the Society and remarks were made by Dr. Sommer, of Trenton, Dr. Fisher, of Bound Brook, and many members.

In times of emergency the members have given unstintingly of their time and ability. During the Civil War several members served in the Army or Navy. And in both World Wars the society was again well represented: both by those who entered the armed forces and by those who remained at home and carried on the examinations demanded by the Selective Service System.

Many men prominent in medicine have been members of this organization, among whom are: George L. Romine, a life-long member; George N. Best, better known as a botanist of international fame; Peter McGill, Enoch Blackwell, now of Trenton, and Samuel B. English of Glen Gardner. Among the Honorary Members are John F. Ward now deceased, J. B. Morrison, G. N. J. Sommer and F. G. Scammell the latter two residing in Trenton.

At the present time, there is a membership of thirty-five which is the largest in its history. There are four meetings each year which are well attended and the interest of the members seems to be on the increase.

HOW EFFECTIVE ARE PREMARITAL AND PRENATAL BLOOD TESTS?

The national spotlight was on New Jersey's premarital and prenatal blood test laws in a paper published in the *Journal of Social Hygiene* in November 1946. The authors, G. S. Usher, M.D., of Trenton, and John Hall of Freehold summarize their study as follows:

"Premarital and prenatal examination laws in New Jersey have been successful. As a case-finding procedure these two laws (since 1939) have been the means of discovering about 1,100 previously unknown syphilitic infections *each year*. Positive *premarital* tests are obtained in eleven cases per thousand. Of the positive premarital cases about one-third are refused certificates for getting married and are therefore presumed to have syphilis in a communicable stage. About eight per cent evade the law by marrying in other states thus demonstrating the need for more uniform laws throughout the country. About half of the cases discovered were under treatment for at least three months after the test.

"*Prenatal* blood tests have been positive in the ratio of about fourteen per thousand. Of the 800 prenatal cases per year with positive tests 23 per cent in 1939, increasing steadily to 50 per cent in 1944, already knew they had syphilis. This is taken to indicate that syphilis case-finding procedures have been increasingly effective in recent years.

"Data indicate a need for renewed efforts to get women to their physicians early in pregnancy and to persuade physicians to take a blood test at the *first* visit of every pregnant woman. A weakness still exists in frequent neglect of careful examination of the baby for syphilis, including a blood test. Until this is universally requested by parents the full benefit of the laws will not be obtained.

"The downward trend of congenital syphilis continues. A substantial part of this trend may be attributed to the premarital or prenatal examination laws.

"Cooperation with these laws by physicians and by the general public has been excellent. With respect to the premarital law the most serious error has been a tendency of a few physicians to consider any patient with a positive blood test as potentially infectious and to withhold marriage certificates. It is not uncommon to receive a letter from a physician asking what to do about a patient with congenital syphilis who is 'Wassermann fast.' The answer is that all such cases should be allowed to marry. With the aid of The Medical Society our Division has set up a definition of potential infectiousness which has been made available to physicians. This has been helpful and there is evidence that physicians are gaining a better understanding of the intent of the laws."

General practitioners, obstetricians, pediatricians and syphilologists will want to read the paper in full. Reprints are available on request to Chief, Bureau of V. D. Control, State Department of Health, Trenton 7, N. J. Ask for the paper "Seven Years Experience with Premarital and Prenatal Examinations in New Jersey" as reprinted from the November 1946 *Journal of Social Hygiene*.

ASSOCIATES AVAILABLE

If interested in establishing contact with any of these doctors, write to The Medical Society of New Jersey at 315 West State Street, Trenton 8, and indicate whether you are referring to notice 16, notice 17, etc.

MATURE GENERAL PRACTITIONER now available as part-time associate for internist, dermatologist or obstetrician in northern New Jersey. Refer to notice 16.

WELL-TRAINED INTERNIST, Board-qualified, will be available in June for association with practitioner in any part of state. Refer to notice 17.

ROENTGENOLOGIST, BOARD-ELIGIBLE, age 39, formerly x-ray chief at army hospital, now available for association with group or with roentgenologist in northern New Jersey. Refer to notice 24.

GENERAL PRACTITIONER with combat experience in traumatic surgery and army hospital experience in internal medicine, age 38, available for association in northern New Jersey. Refer to notice 20.

EXPERIENCED SURGEON, former Navy medical officer, age 42, capable of handling operative work in urology, orthopedics and gynecology, available for association with busy practitioner anywhere in New Jersey. Refer to notice 27.

GENERAL PRACTITIONER desires placement with physician in any specialty in northern New Jersey area. Age 33, veteran, fully licensed in this state. Refer to notice 28.

RADIOLOGIST, BOARD-ELIGIBLE, age 35, has had six years' experience in both diagnostic and therapeutic radiology, formerly chief of x-ray service in army hospital, now available for hospital, group or private office association anywhere in New Jersey. Refer to notice 29.

ASSOCIATION WITH ESTABLISHED INTERNIST OR PSYCHIATRIST in Northern New Jersey desired by physician with wide experience in both specialties. Excellent references and record. Refer to notice 34.

OTOLARYNGOLOGIST, BOARD-QUALIFIED, age 31, available in February for association with EENT man in Northern New Jersey. Refer to notice 35.

OBSTETRICIAN, GYNECOLOGIST, AMERICAN BOARD DIPLOMATE, age 33, licensed in both N. J. and N. Y., available for full-time or part-time association with established specialist or group, preferably in Northern New Jersey. Refer to notice 32.

SOUTHERN NEW JERSEY GENERAL PRACTITIONER, mature, long experience in medical practice, available as associate to internist, pediatrician, obstetrician or as associate to a medical group. Refer to notice 33.

OFFICE SPACE AVAILABLE

A physician interested in any of the following announcements, will be furnished with further details by writing to The Medical Society of New Jersey, at 315 West State Street, Trenton 8. Indicate whether you are referring to notice 21, notice 22, etc.

SPACE AVAILABLE in North Newark area. Refer to notice 22.

SUBURBAN ESSEX COUNTY, office available to specialist or general practitioner. Refer to notice 31.

MEDICAL OFFICE BUILDING in central Newark. Space available as co-tenant with established internist. Refer to notice 21.

BEAUTIFULLY EQUIPPED OFFICE in central Newark area available to surgeon, dermatologist, otologist or gastro-enterologist willing to share space with established internist. Refer to notice 30.

JERSEY CITY OFFICE SPACE AVAILABLE for another specialist as co-tenant with established internist. Refer to notice 36.

OPPORTUNITY FOR YOUNG PHYSICIAN to be associated with, and take over major portion of established general practice, Trenton area. Details at interview. Refer to notice 37.

NEW JERSEY DOCTORS CITED FOR DRAFT WORK

Thirteen New Jersey doctors have been awarded special Certificates of Appreciation by the War Department in token of their labors in processing inductees for the army and navy. The presentations were made on November 20 by Lieutenant Colonel Frank B. Chapman, New Jersey district recruiting officer. The certificates are signed by Major General James Van Fleet, commandant of the district. The doctors honored by this award are:

DR. GEORGE T. BANKER, Elizabeth
DR. FRANK J. COUGHLIN, Kearny
DR. JOHN L. COURRIER, East Orange
DR. GEORGE W. DAVIES, Verona
DR. WILLIAM J. DONAHUE, West Orange
DR. J. G. ENRIGHT, Jersey City
DR. I. E. GLUCKMAN, Newark
DR. SOL LURIE, Newark
DR. EDWARD MURPHY, Jersey City
DR. SAM ORLOFF, Newark
DR. JACOB PILLER, Paterson
DR. N. W. SIVOLELLA, Newark
DR. H. R. VAN NESS, Newark

WILL DIGITALIS GO?

Will digitalis of the U.S.P. be deleted in favor of its several glycosides and join the ranks of nux vomica, ergot, spirit of ethyl nitrite, Blaud's pills, syrup of ferrous iodide, and others, at one time "musts" for the U.S.P. but more recently discarded in favor of newer thoughts in therapy? The very idea of giving up digitalis would have seemed preposterous only a few years ago, but when the committee recognized digitoxin, digoxin, and lanatocide C, crystalline glycosides of digitalis, for the U.S.P. XIII, they may have been sounding the death knell for digitalis itself.

The principle involved is one which has been receiving more and more recognition, namely, the use of specific entities for those preparations not so specific. The several digitalis glycosides have been in increased demand during recent years and it is but natural that they should be given U.S.P. recognition. The marked advantages of giving small doses of specific substances rather than large doses of mixtures have been demonstrated repeatedly. The relatively large dose of digitalis required for rapid digitalization usually results in nausea and vomiting, caused by the large amount of unabsorbed material which must be administered, while the small dose of digitoxin required does not cause this discomfort. It is also noted that when digitalis is used orally it requires several times as many actual U.S.P. units to produce results comparable to those obtained with digitoxin, indicating that the mixed active principles as found in digitalis are not completely absorbed. In the case of digitoxin the drug is absorbed equally well whether given orally or intravenously.

Digitoxin as it will be recognized in the U.S.P. XIII may be either the very highly refined pure glycoside or a mixture of cardioactive glycosides from digitalis purpurea, consisting chiefly of digitoxin. Therapeutically it is impossible to differentiate between the two forms.

Since digitoxin U.S.P. XIII may represent a mixture rather than a precise chemical crystal it will not be possible to determine its purity by melting point, or similar determinations generally used, but the usual digitalis biologic assay will be a requirement. The biologic control procedure is time consuming and expensive, and it is fortunate therefore that there has been developed a comparatively quick method of colorimetric control for estimating the amount of digitoxin present in the tablets and in the injection, which will represent dosage forms of digitoxin in the U.S.P. XIII.

The several digitalis glycosides are now marketed under various names, some of which are trademark titles. Digitoxin is available as such and also under the names digitaline nativelle, crystodigin, purodigin, and cardigin. Digoxin is obtainable under its own title, while lanatoside C is sold under the name cedilanid.

NUTRITION IN EVERYDAY PRACTICE

S. William Kalb, M.D., Newark, N. J.
Chairman Nutrition Committee

1. *What is the advantage of a low cholesterol diet?*

A low cholesterol diet is one in which animal fats are reduced to a minimum and the glandular organs are omitted. This is indicated in cholelithiasis, hypercholesteremia, chronic infection of the gall bladder, in a nonfunctioning gall bladder with obstruction of the cystic duct and in postoperative cases. To plan a low cholesterol diet the following instructions must be followed:

1. Avoid all glandular organs—liver, brains, kidney, sweetbreads.
2. Avoid all oysters, caviar, or roe.
3. Serve only lean meat or fish.
4. Use only 2 egg yolks per week; egg white as desired.
5. Allow a pint or more of skim milk or buttermilk daily.
6. Use only skim-milk cheese, such as cottage cheese. Omit rich cheese, such as cream or Cheddar.
7. Use no animal fats, such as lard and suet, in cooking. Unless fat in diet is markedly restricted, olive oil, Crisco, margarine, mayonnaise, and French dressing and other fats made from vegetable and nut oils may be used.
8. Use vegetables and fruits as desired—prepared without extra butter and cream. (Plant sterols known as "phytosterol" are not absorbed by the gastrointestinal tract to any appreciable extent.)
9. Prepare tapioca, cornstarch, rice pudding, and junket with skim milk and without egg yolk. Whips may be made with gelatin or egg white; no cream.
10. Serve jelly, jam, marmalade, honey, molasses, syrup, and sugar as desired.

2. *What supplements to a normal diet are needed in pregnancy, lactation and childhood?*

In pregnancy: There is a need for an increased amount of proteins, minerals and vitamins. Add to the diet more milk (irradiated), legumes (peas or beans), bread (whole wheat or enriched).

In lactation: There is a need for an increase in all nutrients. Add to the diet an extra pint of milk, cheese, eggs, liver, whole grain cereals, citrus fruit, two tablespoonfuls of peanut butter, cabbage and green vegetables.

In childhood: There is a need for more calories, proteins, vitamins and minerals. Foods containing these must be added in generous quantities to the normal diet.

3. *Is there any nutrient difference between potatoes and sweet potatoes?*

Both are high in carbohydrate content and energy value. Both are good sources of vitamin C. Potatoes are poor, but sweet potatoes are rich in vitamin A.

4. *Some preparations of vitamin D are marked in U.S.P. units and some in international units. What is the difference? Is 500 units a sufficient dose?*

No difference; 10,000 U.S.P. units of vitamin D are the same as 10,000 international units. Five hundred units of vitamin D is infinitesimal and of little value.

5. *What vitamins are retained in some of the common commercial canned foods?*

The following chart shows the degrees of vitamin retention in commercial practices:

	Excellent	Good	Fair	Poor
Ascorbic Acid	tomatoes tomato juice	cherries carrots	asparagus corn spinach	snap beans lima beans peas
Carotene	asparagus cherries spinach tomatoes	carrots corn peas tomato juice	snap beans	
Thiamine	tomatoes	tomato juice	asparagus carrots	snap beans lima beans corn peas spinach
Riboflavin	asparagus tomatoes tomato juice		lima beans corn peas spinach	snap beans
Niacin	asparagus spinach tomatoes tomato juice		carrots corn	lima beans peas

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HEALTH IS NOT AN INALIENABLE RIGHT. It is a privilege. Privileges invariably entail equivalent responsibilities. It is so easy to accept privileges that before long mankind takes them for granted and claims them for inherent rights. Nature grants few rights, preferring to demand that privileges be earned. Health, like freedom and peace, continues only as we exert ourselves wisely to maintain it. Edward J. Stieglitz, M.D., *A Future for Preventive Medicine.*

THE COMMON COLD AND ITS SEQUELLAE, according to Dr. McCastline, Columbia University Medical Officer, was responsible for more loss in time to the student body last year than all other common diseases combined. Of 57,178 separate conditions treated by the Medical Office, respiratory infections ranked first, accounting for 23 per cent of the cases, while digestive disorders were second with 21.6 per cent.

SUPPLEMENTARY LIST OF MEMBERS No. 6

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

Anderson, Windom E., 481 Broad st., Newark (7)
Burokus, William J., 21 E. Pleasant av., Maywood (2)
Conti, Horace, U. S. Marine Hospital, 4141 Clarendon ave., Chicago 13, Ill.
Davis, William J., 144 Harrison st., E. Orange (7)
Dorris, Earl D., Es. County Hosp., Cedar Grove (7)
Flicker, David J., 82 Clinton av., Newark (7)
Garrison, George H. H., Margaret Hague Maternity Hospital, Jersey City (4)
Gordon, Abel, 616 Main av., Passaic (16)
Gordon, Sarah, 327 Cedar Lane, Teaneck (2)
Horowitz, Alexander S., 4614 Blvd., Union City (9)
Jensen, Grover, 451 Bergen av., Jersey City (9)
Keats, Sidney, 179 Lincoln av., Orange (7)
Lehman, Irving J., 31 Lincoln Park, Newark (7)
Lowe, Louise, State st., Hackensack (2)
McGovern, Patrick J., 26 Carlton av., Jer. City (9)
McGuinn, William B., 10 N. Ridgewood rd., S. Or. (7)
Onorato, Vincenzo R., 66 Christopher st., Newark(7)
Pollock, Samuel L., 730 Prospect st., Maplewood (7)
Rattene, Edward, 540 Mt. Prospect av., Newark (7)
Reich, Emma, Essex County Sanatorium, Verona (7)
Reitnauer, John S., Tenafly (2)
Roth, Daniel, 836 Garrison av., Teaneck (2)
Sachs, Fred, 48 Warner av., Jersey City (9)
Scheiber, Geza, 769 Kearny av., Arlington (7)
Smith, Jarvis M., 198 Valley rd., Montclair (7)
Thompson, Edna R., Main rd., Flanders (14)
Wegrocki, Adolph, 588 Sanford av., Newark (7)

ASSOCIATES

Alterbaum, George, 25 Park av., Caldwell (7)
August, Jack, 149 Rhode Island av., E. Orange (7)
Bensel, Arlington, 6 No. Munn av., E. Orange (7)
Comando, Edward N., 695 Clinton av., Newark (7)
Evans, John R., 496 Prospct st., Maplewood (7)
Finkelstein, Aaron, 37 Aldine st., Newark (7)
Gianquinto, Peter J., St. Barnabas Hosp., Newark(7)
Gras, Alfred E., 160 Roseville av., Newark (7)
Hanfling, Seymour L., 115 S. Munn av., E. Orange(7)
Hertzberg, Irving, 240 Graham av., Paterson (7)
Holder, Lester, 29 So. Munn av., East Orange (7)
Judge, Thomas V., Jr., 514 Mt. Prospect av., N'k.(7)
Kawalek, Roman, 46 So. Burnett st., E. Orange (7)
Kenny, James J., 392 Tremont av., Orange (7)
Mason, John T., Jr., 118 Young av., Cedar Grove (7)
Murray Edward F., 575 Highland av., Newark (7)
Pilpel, Michael, 82 Lyons av., Newark (7)
Rath, Maurice, 140 Fourth av., East Orange (7)
Ritota, Michael C., 7 Salem st., Newark (7)
Rubin, Sidney, 170 Hawthorne av., Newark (7)
Schwartzfeld, Hyman, 301 Stuyvesant av., New'k(7)
Sharlin, Herbert S., 745 So. 10th st., Newark (7)
Smith, Alan L., 32 Washington st., East Orange (7)
Van Amberg, Robert J., 85 S. Harrison st., E. Or.(7)
Wannemacher, Paul H., 173 Maple st., W. Orange(7)
Weiss, Fred, 254 Wainwright st., Newark (7)

OBITUARIES

DR. GROVER T. APPLEGATE

Finis was written to one of the longest medical careers in the United States on November 4 when Dr. Grover T. Applegate of New Brunswick died at the age of 87. Dr. Applegate was born in Red Bank in the days when James Buchanan was President of the United States. He was a school teacher for some years, but received his medical degree from the Hahnemann Medical College, Chicago, in 1883. After a year of practice in the midwest he returned to his native state and was engaged in the general practice of medicine in New Jersey since 1884. He served the country as a member of the Medical Advisory Board of the Selective Service System of the first World War, and his interest in civic affairs included a long period of service on the Board of Water Commissioners and the Board of Education of the city of New Brunswick. For many years he was president of the Board of Water Commissioners. He was a director of the Y. M. C. A. and at one time was President of the New Jersey Homeopathic Medical Society.

DR. NATHANIEL B. STANTON

Dr. Nathaniel Brown Stanton, senior attending surgeon at the Muhlenberg Hospital, died suddenly on October 17, 1946, at the age of 53. Born in upstate New York he matriculated at Cornell University Medical School in 1916 and was graduated in 1920. After a two-year internship in New York he came to Plainfield and established an office in that city in 1923. Always interested in surgery, he advanced rapidly from junior attending surgeon in 1927 to senior surgeon in 1936 at Muhlenberg Hospital.

Early in his medical career Dr. Stanton volunteered for service with the Grenfell Medical Mission in Labrador, where he served as doctor to the Eskimos for a year. During World War II he was chief of emergency medical service of the Plainfield Defense Council.

DR. FRANCIS J. SHORT

Dr. Francis J. Short, for twenty years Jersey City police surgeon, died suddenly on November 4 while holding office hours at his home in Jersey City. Dr. Short was born in Brooklyn in 1881, but lived in Jersey City most of his life. He was graduated from Georgetown University School of Medicine in 1904. He was on the staff of St. Francis Hospital.

DR. OTTO WAGNER

Union County lost one of its oldest and most colorful general practitioners on October 22, 1946, with the death on that day of Dr. Otto Wagner. Born in the Rhineland 74 years ago, Otto Wagner was first a pharmacist in central Germany. He came to the United States in 1893 and matriculated in the Medical College of Cornell University a few years later. After interning at the Elizabeth General Hospital he opened an office for general practice in 1905. He was one of the organizers of St. Elizabeth Hospital in Elizabeth.

Dr. Wagner was always active in civic affairs. In 1907 he was city physician, in 1910 he was a councilman, and in 1914 he became a member of the Board of Fire Commissioners, a post which he held until the day of his death. He was always interested in the work and men of the Fire Department and was one of the few holders of an honorary membership card in the Eastern Association of Fire Chiefs. He was also biologist of the Crime Detection Laboratory.

DR. HELEN E. WEITHAASE

With profound sorrow the members of the Cumberland County Medical Society record the death on August 6, 1946, of Dr. Helen E. Weithaase of Vineland. She was an old and valued honorary member of the Society for many years, regular in her attendance and deeply interested in its activities until the last. Dr. Weithaase was at one time elected president of the Cumberland County Medical Society, and was one of the first women physicians in the state to be elected to such high county office. She was born in 1874 and was graduated from the Women's Medical College of Philadelphia in 1908.

BOOK REVIEWS

Manual of Clinical Mycology. Prepared under the auspices of the Division of Medical Sciences of the National Research Council. W. B. Saunders Co. 1944. Philadelphia.

Mycology has been one of the least stressed sides of pathology as taught in the medical schools. The prevalence of fungal diseases and their varying clinical manifestations have been emphasized during the war. Quoting from the preface of the authors, "Fungus infections are of such common occurrence that we have found it necessary to consider mycotic disease in the differential diagnosis of practically every obscure infection."

This volume presents the field in a concise fashion and by its resume of differential diagnosis, points the way to further study. The chapters on dermatomycoses are especially to be recommended, since most patients suffering from them go first to the family doctor for help. Prompt recognition of the cause of the disease then, may shorten the illness greatly.

The portions dealing with the fundamentals of mycology, giving morphologic classifications, colony appearance and laboratory methods in identifying fungi, as well as the descriptions of the gross and microscopic findings in the diseased tissues will be of great help to the pathologist.

This volume, with its well organized and accurate subject matter, is a very welcome addition to the physician's library. CAMILLE MERMOD, M.D.

Mongolism and Cretinism. Clemens E. Benda, M.D.—Harvard Medical School. Published by Grune & Stratton, 298 pages, $6.50.

This valuable book is welcome to those of us who deal with genetic and endocrine factors in sterility. There is a definite increase in the number of couples with relative infertility and sterility, who consult physicians for relief of sterility. In view of the thorough analysis of mongolism and cretinism by Dr. Benda it becomes questionable, whether it is advisable to induce fertility in a couple who exhibit either stigmata of endocrine imbalance, psychic lability or instability of the circulatory or autonomic functions of the body. These factors have been shown by the author to play an important role in the etiology of mongolism.

This scholarly book presents an exhaustive study of the problems of mongolism and cretinism with a most extensive list of references.

The twelve chapters cover every phase of these two conditions including a historical review of these diseases, their incidence, etiology, geographic distribution prevention and treatment. The physical characteristics are minutely analyzed, with detailed skeletal measurements, x-ray studies and extensive hematologic and biochemic investigations.

Cretinism offers the best possibilities as far as prevention, treatment and prognosis are concerned. Iodized salt in areas where endemic goitre is prevalent tends to prevent goitre formation; when goitre is already present, its surgical removal and

administration of thyroid substance have excellent effects. In sporadic cretinism, the administration of thyroid substance gives dramatic results.

The problem of the mongoloid child is more depressing and the condition is resistant to therapy, because the disturbance is too profound, affecting practically every organ of the body. The endocrine system, heart, liver, kidneys and gastro-intestinal tract show stigmata or underdevelopment and degenerative processes; the same holds true of the osseous, circulatory, nervous and muscular systems. Little can be expected from endocrine therapy in the face of such a profound disturbance. It is the author's opinion that prenatal arrest of the anterior pituitary gland is responsible for the impaired somatic and mental growth of the mongoloid. He feels that early administration of potent extract of anterior pituitary from young growing animals would be of great value. Of the various fractions of the anterior pituitary, he considers the thyreotropic hormone as the essential one needed by the mongoloid.

As far as prevention is concerned, the author advised a thorough laboratory and endocrine analysis of every prospective parent, especially the mother, and the correction of any physical or endocrine disturbance in both prospective parents.

Since the greatest incidence of mongoloid birth occurs in women past the age of 35, the factor of age must be seriously considered. Other unfavorable factors are emotional instability, neuro-circulatory disturbances, and signs and symptoms of constitutional inferiority.

This book is a "must" in every physician's medical library.

RITA S. FINKLER, M.D.

Peripheral Nerve Injuries, by Webb Haymaker, Major, M.C., A.U.S., and Barnes Woodhall, Lt. Col., M.C., A.U.S., Philadelphia. W. B. Saunders Company, 1945.

This small volume has filled a war need in the treatment of peripheral nerve injuries. Purpose of the book is to clarify the problems associated with accurate diagnosis and this is well accomplished in the clear and concise text and excellent illustrations.

It would seem, however, in view of the small size of the book, that less space might be devoted to segmental innervation in the second chapter and that the accompaning charts might be condensed.

In chapter five, the procedure in examination and electromyography might have received more comprehensive consideration.

While the book makes no attempt to deal with treatment, its usefulness, especially in military practice, might be increased if brief, well illustrated chapters were added dealing with the surgical approach to nerve lesions and the management of the common trophic disturbances and causalgias.

This work should fill a postwar need as a concise, practical reference work, especially for the student, intern and practitioner whose civilian practice will deal with the diagnosis and treatment of traumatic disorders.

Dentistry — An Agency of Health Service, by Malcolm Wallace Carr, D.D.S., Commonwealth Fund, New York, 1946. $1.50.

Dentistry has made phenomenal strides in the last one hundred years, changing from a biomechanical craft to professional status. Many aspects of the practice of dentistry are dealt with, briefly but comprehensively, beginning with its history and including educational problems, dental practice, hospital services, industrial dentistry, dentistry in public health, practice in rural areas and dentistry for Negroes. It also deals with preventive dentistry, problems for investigation and current progress, dental materials and dental socio-economics.

In comparison with medical practice several glaring differences are revealed. According to the 1940 census more dentists are retiring than are being graduated each year. Little money is available for research. In no insurance plan is it possible to distribute the demand for services because almost everybody has "caries" and would avail himself of services whether these were free or on an insurance basis.

The maldistribution of dentists is particularly stressed. In 1940 in 29 states, there were no practicing dentists in 212 counties with a population close to one million. In many rural areas where dentistry was available citizens had to travel a considerable distance. Organized dentistry is trying to come to grips with this problem and is willing to endorse any national scheme for better distribution of services providing that the program is controlled by the American Dental Association and management is on a local basis. The American Dental Association cannot assume full responsibility, but is anxious to cooperate, as it is now doing in an experiment in two large cities in which fluorine is added to drinking water for caries control.

Although dental diseases develop recurrently in practically every person, about three quarters of the people of the United States obtain very little dental service other than extractions. The ideal of comprehensive and personally all-inclusive dental health care is not now attainable owing to obstacles that, at present, are insurmountable. This is a challenge to continual constructive endeavor for the nearest possible realization of that ideal. Dr. Carr lists the following obstacles: (1) Lack of desire for and reluctance to seek such dental health care. (2) Insufficient numbers of dentists, in proportionate distribution throughout the country, to perform adequate services for the entire population, and (3) the relatively high costs of dental health services.

The volume as a whole is characteristic of a relatively young profession. One gets the impression that the dental profession is jealous of its rights to "independence" of the medical profession, although claiming close professional kinship. Much stress is laid on a tremendous growth from humble beginnings to a full-fledged profession in but a single century. It is also evident that the dental profession is becoming disturbed by the public clamor for a more equitable distribution of its services, but its present position is that of an adolescent who is on the defensive. The problem seems too much for them to solve alone.

A. WOLFSON, D.D.S.

COUNTY SOCIETY REPORTS

ATLANTIC COUNTY

A. G. Merendino, Reporter

JOHN ALLAN BERTOLET, M.D., Coroner of Philadelphia County, was the guest speaker at the meeting of the *Medical Society of Atlantic County* held at the Traymore Hotel on Friday, October 11, 1946. His subject was *The Necessity for Autopsies by the Coronor.*

Dr. Bertolet first related the history of the position of coroners. It was amazing to learn that in the long history of the position of coroner in Philadelphia County, only 3 physicians have occupied the office. In order to fulfill the office properly, one should possess both legal and medical knowledge.

Cases that come under the jurisdiction of the coroner include all suicides, homicides, suspicious cases of death, accident cases, and deaths of persons who have had less than 24 hours of medical attention. All hospitals must furnish necropsy reports to the coroner. Dr. Bertolet stressed the importance of inquests.

Dr. Bertolet said that child deaths present a severe problem in Philadelphia. These deaths are chiefly from parental neglect and suffocation either from regurgitated food or from smothering due to too many sleeping in one bed.

The coroner's office includes a chief deputy coroner, chief deputy physician, chief clerk, file clerk, two district deputies, three court clerks, and three stenographers. Before concluding his paper, Dr. Bertolet introduced his chief deputy, Mr. Roth, who added humor by relating actual happenings in the morgue. He stated that they average 23 to 26 cases per month; and that half of their homicide cases end up as first degree murder.

PRESIDENT WILSON thanked both speakers on behalf of the society.

DR. BALDWIN L. KEYES was the guest speaker at the regular monthly meeting of the *Atlantic County Medical Society,* held at the Traymore Hotel on November 8, 1946. Dr. Keyes spoke on *Developing Useful Potentials in Neuroses.* He stressed the importance of combining the past methods of treatment with those of the present. Emphasis was placed on the fact that everyone possesses certain potential asset qualities which are not recognized and never utilized and some which are only rarely noticed. The speaker stated that getting the neurotic patient to exercise these hidden potentials helps immeasurably in making a well patient out of a very ill one.

Dr. Keyes is a great believer in on-the-job treatment. While many patients have to be placed in institutions for treatment, many more can and should be treated while working. Careful guidance so planned that it causes as little interference as possible with the rebuilding of the man as a useful community asset is the best form of treatment.

The speaker concluded his paper by stating that the neuropsychiatric veteran is now one of our largest economic problems and that obviously it will be impossible to carry out a prolonged investigative program in most of these cases.

Dr. Keyes' paper was discussed by DR. MATTHEW MOLITCH.

DR. LAWRENCE WILSON thanked the speaker.

BERGEN COUNTY

H. E. Reinhold, M.D., Reporter

The Regular Meeting of the *Bergen County Medical Society* held at Bergen Pines Hospital, Oradell, N. J., on the evening of October 8, 1946, was called to order by the president, DR. ALBERT W. CLOUD, at 9:15 p. m.

Minutes of the regular meeting of September 10th were accepted as read. Minutes of the executive committee meeting of September 17th were approved as published in the BULLETIN.

On recommendation of the membership committee, the following applicants were elected to full membership: DR. ABRAM WEISS, Teaneck (by transfer from Hudson County); DR. HAROLD DAVIS, Bergenfield; DR. AMEDEO C. NACLERIO, Woodbridge; DR. ROBERT W. DUFFY, Hasbrouck Heights; DR. ANTHONY J. PERSICO, Harrington Park, and DR. NATHAN F. VOGEL, Ridgefield Park, were elected to associate membership.

President Cloud reported that a joint meeting of the executive committee and the veterans' liaison committee had been held October 3rd. At that meeting is was voted that the Bergen County Medical Society organize a nonprofit corporation, to be known as the *Bergen County Medical Plan for the Care of Veterans,* for pension examinations, and that a group of five members of the Bergen County Medical Society be appointed to act as officers.

Speaker of the evening, DR. FRANKLIN A. STEVENS, Chief of Allergy, Vanderbilt Clinic, New York, was introduced by DR. GEORGE HELLER. He delivered a very interesting talk on *Value of Anti-Histamine Therapy in Allergic Conditions.* Dr. Stevens discussed the history of substances used in the treatment of allergies, such as histamine desensitization, histaminase and the hapamines, as well as some of the proprietary medications that have been in vogue from time to time. Results of the use of these substances has been disappointing up to the present. He then discussed in able detail the newer preparations, benadryl and pyribenzamine. He has found these highly effective in the allergic states, but they are by no means cures. He felt the best attack was by the use of desensitizing substances. There was a lively question and answer period following this very excellent presentation by Dr. Stevens.

The meeting adjourned at 10:15 p. m.

BURLINGTON COUNTY

T. B. Dickson, M.D., Reporter

The first meeting of the *Burlington County Medical Society* for the year 1946-47 was held at the Riverton Country Club on September 12, 1946.

Guest speaker, DR. SAMUEL LLOYD, was introduced by DR. JOSEPH KUDER. Dr. Lloyd, who is attached to the Veterans Administration, spoke on the big job that is ahead in the examination of veterans applying for a pension. In Burlington County there are now 4,000 veterans applying for pensions and there may soon be more. Each veteran gets three physical examinations. Dr. Lloyd suggested that each county take care of its own veterans. He suggested that one or two clinics be established in the county. The personnel of the clinics should be made up only of those approved by the county medical society. Both the clerks and physicians will be paid by the Veterans Administration.

After Dr. Lloyd finished there was a complete discussion led by Dr. Joseph Kuder, Dr. F. F. Borzell and Dr. Marcus Newcomb.

General opinion of the members was that the county medical society should work out the details and organize one or more clinics in this county.

It is with great sorrow that the Burlington County Medical Society announces the death of DR. PARRY M. SCOTT of Beverly in July 1946 and DR. DANIEL F. REMER of Mount Holly in September.

On October 10, 1946, the *Burlington County Medical Society* held its monthly meeting at the Riverton Country Club.

DR. WILLIAM BRAY, president, introduced the guest speaker DR. J. QUINTIN GRIFFITH of the University of Pennsylvania who spoke on *hypertension*. Dr. Griffith and his co-workers have done a great deal of experimentation in hypertension. He described two types of hypertension: active and inactive. In the former, the chemical is present in the blood that causes hypertension; and in the latter the chemical has disappeared but the hypertension remains. Chief causes of active hypertension are found in the kidneys, or in the pituitary gland—(mostly in posterior lobe) or in the adrenal glands or in lesions in the capillaries such as increased permeability. If possible, removal of the cause is the treatment of choice. In inactive hypertension, thiocyanates are the drugs of choice. This talk was a most instructive one on a very baffling subject.

DR. JOSEPH KUDER read a memorial to Dr. Daniel F. Remer.

The chairman of the Liaison Committee to the Veterans Administration, Dr. Joseph Kuder, read communications from the Administration and told of the difficulties in setting up veteran's clinics.

New members elected to the County Society at this meeting are: Dr. Edward F. Mazur, Riverside; Dr. Edward D. Wildman, Moorestown; Dr. Morris A Robbins, Columbus; Dr. Alfred M. Elwell, Moorestown; Dr. John C. Whitaker, Riverton, and Dr. Daniel E. Boyle, Beverly.

CUMBERLAND COUNTY

Norman W. Henry, M.D., Reporter

Under the chairmanship of DR. ALBERT KUMP, its president, the *Cumberland County Medical Society* held its fall meeting on October 8, 1946, at Richard's Farm, Rainbow Lake, Vineland. Guests were DR. RALPH PHILLIPS, DR. MAURICE HARRIS, DR. PASQUALE RUGGIERI and DR. HAROLD HENDRICKSON.

A veterans' liaison committee was appointed consisting of DR. CHARLES CUNNINGHAM, DR. ANTHONY PINO and DR. JAMES KNOWLES. This committee functions under the organization of DR. EDWARD T. YORKE, Medical Liaison Officer to the Veterans Administration in New Jersey. Dr. Cunningham made an extensive report of the veteran liaison committee meeting concerning the organization in Cumberland county, of a nonprofit organization similar to the Monmouth county plan. He stated that expediency in setting up this plan is most desired. The members favored the office examination system rather than group clinics. In this way the 1200 needed examinations would be completed in two months.

A brief discussion concerning the organizing of a women's auxiliary was held and it is the opinion of the executive committee that such a group organization was not feasible in this county.

The deaths of DR. J. FRANKLIN REEVES and DR. HELEN E. WEITHAASE were announced and resolutions are to be forwarded to their families and entered in our society records.

Guest speaker was DR. WILLIAM G. LEAMAN JR., Professor of cardiology at Womens College of Pennsylvania, who spoke on *Modern Treatment in Cardiology*. A national program for the prevention and treatment of rheumatic heart disease is necessary he stated. The use of sulfadiazine and sulfamerizine has decreased the number of relapses in these cases according to the Army and Navy studies. He feels that insistense on rest can be overdone and favors mild exercise. Operation in congenital heart disease is most promising especially in cases of the Tetralogy of Fallot and patent ductus arteriosus. The use of penicillin in treating subacute bacterial endocarditis has increased the proportion of cures. A renal block agent is now being sought to maintain a high blood concentration of this drug. He favors the mercurial diuretics followed by digitalization for the treatment of heart failure. He commented about the recent publication on the toxicity of mercurial diuretics and stated that he felt many of these cases are actually digitalis poisoning caused by the concentration of the digitalis drug in the body fluids. In coronary heart disease and angina, the important need is for collateral circulation. He concluded with the subject of essential hypertension and the value of the Smithwick operation.

A dinner was served following adjournment of the meeting.

The officers and members of the *Cumberland County Medical Society* wish to express to Mrs. J. Franklin Reeves and daughter, Christine, their feeling of great sympathy over the death of Dr. Reeves on September 18, 1946.

Our Society has lost one of its most valuable and

honored members. Dr. Reeves served through-out the years of his practice in many positions of trust. His shrewd judgement and good common sense made him respected by all. Dr. Reeves was one of the stabilizing forces within the Society and his quiet words were always sobering in times of heated lebate. His home life and professional life were models that could well be copied by all men. The nobility of his character lifted him above all pettiness and conceit. The present members of this Society who loved him well, will miss him always.

ESSEX COUNTY

Felix J. Di Fino, M.D., Reporter

Dr. Thomas W. Harvey, President, presided at the November meeting of the *Essex County Medical Society,* held at Merck Hall, Orange, on Thursday, November 14, at 9:00 p. m. This meeting featured a symposium on *"Recent Developments in the Medical and Surgical Management of Biliary Tract Diseases.* Dr. R. Franklin Carter, of the Post-Graduate Hospital, New York, was the first speaker of the evening. Dr. Carter outlined a seventeen-year study of infection in gall bladder disease. A most thorough description of methods of diagnosis and treatment of jaundice was then given by Dr. John Russell Twiss, also of the Post-Graduate Hospital, New York.

The following applicants were elected to membership:

Reinstatement: C. Joseph Ferri and Geza Frank, Newark; Charles O. Leff, South Orange.

Transfer-Active: Harrison D. Goehring, Montclair, and Albert G. Hulett, East Orange.

Active: Abraham Leff, Newark.

Associate: Jules H. Bromberg, Jerome L. Leon, Norman Panzer, C. Richard Weinberg, Harry C. Wortman, Newark; Frederick W. Douglas, Montclair, and Janet L. Eckhardt, South Orange.

HUNTERDON COUNTY

Edgar W. Lane, M.D., Secretary

Hunterdon County Component Medical Society celebrated its one hundred and twenty-fifth anniversary on October 30, 1946. The occasion was a dinner meeting at the Clinton House, Clinton.

Twenty of the thirty-three members of the Society were present. Also present were J. Howard Hornberger, M.D., first vice-president, and James Norton, M.D., second vice-president of The Medical Society of New Jersey. Other visitors included Dr. George N. J. Sommer, Sr., an honorary member of Hunterdon County Medical Society, Dr. George N. J. Sommer, Jr., and Dr. Max Gross, a former member.

Dr. Philip W. Baker, president of the Society, acted as toastmaster. Dr. Baker welcomed the new members of Hunterdon County Medical Society and guests to this celebration.

Dr. B. S. Fuhrmann gave a history of Hunterdon County Medical Society from its inception in 1821.

Dr. M. H. Leaver of Quakertown, N. J., our oldest member, gave a talk on his early practice and experiences, which was very interesting when compared with present day medicine.

Dr. Frederick Decker of Frenchtown, N. J., second oldest member related his early experiences and said he had enjoyed the practice of medicine and had no regret that he had chosen the profession.

Dr. Baker introduced Dr. Hornberger, who expressed pleasure at being present to help celebrate our 125th anniversary and brought with him felicitations from Burlington County and The Medical Society of New Jersey.

Dr. Baker then introduced Dr. James Norton.

Dr. Norton said Hunterdon County Medical Society was well known in the State Society, especially through the efforts of Dr. Samuel B. English and Dr. Barclay S. Fuhrmann. Dr. Norton emphasized the importance of the clinics now being formed to examine veterans, and said it was a challenge to the medical profession to solve the problem or admit defeat.

Dr. George N. J. Sommer, Sr., related his early association with Hunterdon County Medical Society and his intimate association with some of its members. He told of many occasions when he performed operations in homes for some of our old members.

MONMOUTH COUNTY

Helen E. Jones, M.D., Reporter

The Monmouth County Medical Society held its regular monthly meeting on Wednesday, October 30, at the Monmouth Memorial Hospital. Dr. James Pregnall, the president, called the meeting to order at 9 p. m. The program began with the scientific session. Dr. Jerome Kaufman, assistant professor of Medicine at the New York School of Medicine and the guest speaker, was introduced. His subject was *Pulmonary Embolism—Etiology, Symptomology and Treatment.* Dr. Kaufman's paper presented this medical accident completely and clearly. The differential diagnosis, the prophylactic and the active treatment was presented in detail.

After Dr. Kaufman had presented his paper a representative of each of the interested departments spoke on the subject. Dr. O. R. Holters, representing the surgical department, expressed the opinion that pulmonary embolism is as frequent in medical patients as in surgical patients but that it is not as obvious. It appears more frequently in the surgical records because these patients are usually in the hospital; and they have more postmortems performed on them. Dr. Ferguson gave the views of the pathologist. The orthopedic department was represented by Dr. Hobstein. Dr. Altschul presented the medical opinions. Dr. Kaufman graciously answered their questions, and received a vote of thanks for his interesting paper.

The business session promptly followed the scientific portion. Minutes of the last meeting were read and approved. A report of the executive committee was given. One associate member, Vincent M. Whelan, was elected by ballot. The meeting was adjourned at 10:45.

WOMAN'S AUXILIARY

PRESIDENT'S MESSAGE

Mrs. F. G. Wandall, Clayton

To all Auxiliary members and their families I extend Christmas greetings.

The pages of 1946 are full. Every family will celebrate December 25th in a different way; Each looking through the "Book of Life" with varying degrees of emotions.

To you who were not separated from loved ones during the war years and the year of readjustment, this will be a happier Yuletide, knowing the vast destruction of humanity has ceased, and that a lasting peace is the goal most desired by peoples all over the world.

To you whose loved ones served in the armed forces, this Christmas will have added meaning, and you will be filled with a deep happiness, because your family is again complete.

To you who have lost members of your family to that Eternal Life, either through the cruel fate of wars, or by the natural ebb of life, the Yuletide will not have that keen zest of happy years gone by. But God and time have a way of healing such wounds, and you will go on in a full life.

During this season of the year, friendliness and friendships are paramount. Small pettiness and selfish bickering are replaced with kindly deeds and joyous gatherings. Families are reunited, happy tales re-told. The fortunate share with the unfortunate; the wealthy give to the needy. The well and strong administer to the sick and weak. The wise are tolerant of the young. Youth is kind to the aged.

It is truly a time of rejoicing. What a beautiful world this would be if the Christmas spirit invaded the twelve months of the year. What a noble crusade for men all over the earth: To perpetuate the ideals of Christmas, and make them everlasting.

AUXILIARY REPORTS

Atlantic County

Mrs. Samuel L. Salasin, Chairman Press and Publicity

The *Woman's Auxiliary of Atlantic County* met in the Hotel Traymore, Friday, November 8, 1946, at 8:45 p. m.

Mrs. Charles Hyman, president, presided.

A letter of thanks was read from Mrs. Frederick G. Wandall, president of the Woman's Auxiliary to The Medical Society of New Jersey for the fine hospitality extended to her during her visit at our first regular Autumn meeting. Mrs. Hyman gave an interesting report of the board meeting of the State Auxiliary held October 14, in the State Society building in Trenton. She also brought greetings and a message from Mrs. Jesse D. Hamer, president of the Woman's Auxiliary to the American Medical Society. Corresponding secretary, Mrs. Louis Rosenberg, read the 10 point program outlined by the Auxiliary to the A.M.A. A letter from the national *Hygeia* chairman for the promotion of *Hygeia,* was also read.

Mrs. Daniel C. Reyner, Chairman of Widows' and Orphans, explained the plans of that society, stating there were 530 members in the state and invited membership into this worthwhile assurance plan. At present there are only 21 members in Atlantic County.

Mrs. Anthony Merendino announced that a card party would be held in the spring.

Mrs. James H. Mason, reported on Arts, Hobby and Medical History and stated that she had sent out 51 forms and wished the doctors would take heed and follow through with the biographies.

Mrs. Ruffin G. Stamps, Chairman of Arrangements, announced that a Christmas party would be held on December 13, at the home of Mrs. James H. Mason. Mrs. Morton Major, Mrs. Matthew Molitch and Mrs. Samuel Halpern are vice-chairmen of this affair.

The program chairman of the evening, Mrs. Robert A. Bradley introduced the guest speaker, Mrs. Mathias Krenn who reviewed the book "Assignment in Utopia" an autobiography of six years in Russia. Eugene Lyons wrote the book, as a press reporter in Russia, having seen the eradication of the Trotsky regime. Mrs. Krenn gave glowing accounts of the Kremlin—Stalin group who instituted the 5 year plan; she also mentioned that the women in Russia, as well as men, had to produce for the good of the country particularly in agricultural centers. Mrs. Krenn thrilled the audience with her comprehensive report of this book.

Among those present were: Mrs. Charles Hyman, Mrs. Patrick J. McGahn, Mrs. P. C. Martucci, Mrs. Edward Gulon, Mrs. Andrew M. Smith, Miss Ger-

trude Guion, Mrs. Sidney Rosenblatt, Mrs. Morton Major, Mrs. William Hersohn, Mrs. Irving Shavelson, Mrs. David B. Allman, Mrs. Samuel Kaman, Mrs. Daniel C. Reyner, Mrs. Matthew Molitch, Mrs. Samuel Halpern, Mrs. Albert H. Breese, Mrs. Lawrence A. Wilson, Mrs. V. Earle Johnson, Mrs. Anthony Merendino, Mrs. Robert A. Bradley, Mrs. Manuel J. Mally, Mrs. James H. Mason, Mrs. Bernard Crane, Mrs. Ellis Allar, Mrs. Harold J. Bayer, Mrs. G. Ruffin Stamps, Mrs. Edward H. Dyer, Mrs. Baxter Timberlake, Mrs. Martin Green, Mrs. Louis Rosenberg and Mrs. Samuel L. Salasin.

Hudson County

Mrs. Sidney Chayes, Chairman of Publicity

The *Woman's Auxiliary to the Hudson County Medical Society* met on November 4, 1946, at the Young Women's Christian Association, Jersey City. Mrs. Edward A. Murphy, president, presided at the meeting.

Plans for the open health meeting to be held in March were discussed. Topic for the essay contest to be held for the senior high schools is to be "Cancer". The winner will receive the "Minnie Freile Memorial" in honor of our late foundress.

Mrs. Andrew Ruoff of Union City is chairman of Public Relations. The state chairman of *Hygeia*, Mrs. Edward A. Murphy gave a talk on this magazine and stressed strongly the importance of each member's willingness to do her part, in acquainting her friends with *Hygeia*, thereby promoting this source of information on good health to the lay people. It is for this purpose that physicians spend much time and labor writing for this valuable periodical. It was requested that cooperation be given to the County Chairman, Mrs. F. DeVincenzo of Hoboken, for it is only through teamwork that success is produced.

After the business meeting was adjourned, Mrs. William Gleeson program chairman, introduced the guest speaker, Miss Annette Cornell, from the New Jersey Bell Telephone Company. Her subject was "Famous Ladies in New Jersey". Pictures accompanied the talk and they were shown by Mr. Webb.

Tea followed with Mrs. Edward Gilmay Waters as hostess.

Mercer County

Mrs. Joseph R. Burns, Chairman, Press and Publicity

The regular meeting of the *Women's Auxiliary to the Mercer County Medical Society* was held at the Medical Society Building on Friday, November 1, at 2 o'clock.

Mrs. Ernest Purcell, president, welcomed the members and guests to the first meeting of the season. A donation of ten dollars was sent to the Community Chest fund.

A committee consisting of Mrs. George Haggerty and Mrs. William McCarthy was appointed to stimulate active membership.

Following the business meeting, Mrs. C. Chester Chianese, program chairman, introduced Mrs. Joseph E. Mott, state chairman of legislation, who led an interesting discussion on socialized medicine.

Tea was served with Mrs. Ernest Purcell and Mrs. George Hutchinson as hostesses.

Middlesex County

Mrs. Norman Rosenberg, Chairman, Press and Publicity

Dr. William Edgar Sherman, Medical Officer of the Highland Park Schools was the guest speaker at the regular monthly meeting of the *Woman's Auxiliary to the Middlesex County Medical Society.* This was held at the home of Mrs. Robert B. Walker, president, in Highland Park, on Wednesday, November 20, 1946. Dr. Sherman discussed the *Health of Public School Children.* The talk followed an Executive Board meeting held earlier in the evening.

Passaic County

Mrs. Irving A. Silverman, Chairman of Press and Publicity

The *Woman's Auxiliary to the Passaic County Medical Society* held its first meeting of the season on October 28, at the home of Mrs. Ralph Vreeland in Ridgewood. Mrs. Albert Markel, newly elected president, presided at the business session.

Guest of honor was Mrs. Frederick G. Wandall of Clayton, President of the State Auxiliary. She gave an inspiring and informative talk on the manner in which local members can serve The Medical Society of New Jersey.

Mrs. Wandall was honored at a luncheon by the officers of the Auxiliary in the Alexander Hamilton Hotel preceding the meeting.

Plans were announced for the coming doctors' dance to be held at the North Jersey Country Club on December 7, by the chairman, Mrs. Joseph E. Mott.

The afternoon's program was a highly interesting discussion conducted by Mrs. Ida Phillips, national secretary for "Education in Alcoholism".

Tea was served following the program with Mrs. William Neer and Mrs. Richard J. McDonald pouring.

Those present were: Mrs. Earl L. Warren, Mrs. Irving Silverman, Mrs. Nicholas F. Scielzo, Mrs. Frederick G. Wandall, Mrs. Joseph E. Mott, Mrs. Anton P. Randazzo, Mrs. Stephen M. Liana, Mrs. Henry D. Bongiorno, Mrs. Dean A. Wry, Mrs. James P. Morill, Mrs. L. J. Bohl, Mrs. E. J. Hatem, Mrs. W. A. Marrocco, Mrs. R. J. McDonald, Mrs. Wayne W. Hall, Mrs. H. M. Gotchman, Mrs. M. Notkin, Mrs. F. Albert Graeter, Mrs. R. J. Vreeland, Mrs. A. M. Schultz.

Also, Mrs. Paul E. Rauschenbach, Mrs. Harry Dawson, Mrs. James S. Gallo, Mrs. Olive D. Zuckerman, Mrs. Theodore Pollock, Mrs. Joseph R. Jehl, Mrs. Meyer Mackler, Mrs. Capell, Mrs. M. S. Joelson, Mrs. T. K. Graham, Mrs. A. A. Allen, Mrs. William Neer, Mrs. Thomas A. Sanfacon, Mrs. James E. Phelps, Mrs. Irving R. Hayman, Mrs. M. A. Shinefield. Mrs. Harry W. Holken, Mrs. Leslie R. Tabor, Mrs. C. S. Tarte, Mrs. Mario Capio, Mrs. A. C. Linares, Mrs. Albert G. Markel, Mrs. Alfred D. Meneve and Mrs. Francis W. Ash.

THE JOURNAL

OF

THE MEDICAL SOCIETY OF NEW JERSEY

Index 1946

Society established July 23, 1766
Journal founded September 1, 1904

VOLUME 43

JANUARY TO DECEMBER, 1946

Published monthly under direction of the
COMMITTEE ON PUBLICATION

HENRY C. BARKHORN, M.D., *Chairman*
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315 WEST STATE STREET
TRENTON 8, N. J.

1946

The Journal of The Medical Society of New Jersey

Volume 43

HOW TO USE THIS INDEX

This is a single alphabetical index. When searching for an original article, look under the first significant word in the title. Authors are also listed alphabetically, with an asterisk (*) to indicate if reference is to an original article. Editorials are indexed by first significant word of title or by subject; book reviews by title or subject but not by author. City of residence is indicated for authors of original articles.

If you do not bind your Journals, use the table of pages (below) to find the month of issue to which any page citation refers.

The Official List of Members and Fellows will be found as the Supplement to the April issue. The Transactions of the Annual Meeting appear as a supplement to the August issue.

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* Original Articles
† Obituary
e—Editorial
br—Book Review
ab—Abstract

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Tuberculosis Abstracts

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XIX **December, 1946** **No. 12**

A GOLDEN opportunity may be lost if the physician who tells a patient that he has tuberculosis does not at the same time start him on the path to recovery by convincing him of the necessity for hospital treatment. The best interest of the patient is served when diagnosis, treatment and post-sanatorium care are an uninterrupted series of steps with the physician and the sanatorium guiding an understanding and cooperative patient.

THE PSYCHOLOGICAL MOMENT IN THE TREATMENT OF TUBERCULOSIS

The growing importance of preventive medicine and the wider recognition of emotional problems in illness emphasize the teaching role of the modern medical man. This is no new responsibility for physicians, though many have been inclined to forget it during a period when scientific discoveries have dominated the medical scene. The physician always deals with more than a collection of organs in varying degrees of dysfunction. He is concerned with a human being.

This human being who comes with his questions and his needs to the physician requires first of all, a diagnosis—that is a recognition and an evaluation of his physical state. Diagnosis may be difficult or easy. But even as the symptoms are being elicited, the physician is already seeking the facts and making the observations which will guide him when he acquaints the patient with the situation and prepares him for whatever treatment is necessary. It is then that the doctor functions primarily as a teacher and a friend. It is at this time that he may utilize to advantage the principles and practices of education.

"There is a tide in the educational life of a child or of an adult," says one educator, "when one is in a position to learn efficiently and rapidly. Leaders watch for these *teachable moments* and utilize them to their fullest." The teachable moment is also called the psychological moment.

The time at which the physician acquaints the patient with his diagnosis, especially when it is that of a chronic disease such as tuberculosis, is such a moment. It is then that the fearful patient listens intently in order that no word of the physician, no implication of his tone or manner will escape notice or be given less than its true importance. It is often, at this time, that the foundation is laid for a successful recovery from tuberculosis. Sometimes, unfortunately, the opportunity is wasted, with disastrous consequences.

To assemble the facts, to weigh the possibilities, to help the patient face the reality and to be ready with constructive plans, calls for great skill on the part of the physician. He must make sure that the implications of the diagnosis are understood, yet he must be as optimistic as the facts warrant. He must stress the necessity for a drastic change in the life and plans of the patient, yet never proceed faster than the patient is ready to go along with him in his thinking. If handled hurriedly or casually, the patient may refuse to accept the diagnosis; he may delay or postpone treatment; or he may undertake his cure in so rebellious or apathetic a spirit that he nullifies the best efforts of the hospital and medical staff. What happens to an individual tuberculosis patient is often determined by the attitudes and teaching of the physician who first makes the diagnosis. It is then that treatment really begins. In tuberculosis the sequence of diagnosis, treatment and rehabilitation should always overlap and be woven together as a well-spliced rope.

What is the duty of the physician to the man or woman on whom he makes a diagnosis of pulmonary tuberculosis. It depends on his findings in the individual case. If the patient has active

tuberculosis, it should be discussed as a communicable disease. With full consideration for the patient's intelligence, and temperament, the physician should tell the patient that he has tuberculosis. He should not overestimate nor underestimate; he should give the patient the facts as he then sees them.

It is quite possible, by properly taken stereoscopic pictures, to determine almost exactly how much tuberculosis the patient has. It is quite impossible by X-ray pictures alone to establish the degree of clinical activity, perhaps the most important aspect of the prognosis. The patient should be told that only after consideration of clinical and laboratory findings, of constitutional symptoms, and of his response to treatment as shown by the X-ray can any estimate of the length of time required for treament be made.

Time does not usually permit the physician who makes the diagnosis to educate the patient in matters of tuberculosis. He should, however, never dismiss the patient without making sure that he has accepted the necessity for treatment. Until this acceptance is obtained, progress along other lines should not be attempted. This may take time, and the help of the public health nurse and the social worker. A confirmatory diagnosis by a tuberculosis specialist may be required. But until hospital treatment is initiated the patient is under the care of the physician who made the diagnosis. The responsibility for sound and careful guidance, for the protection of the family and for interim treatment rests with him.

Once the patient is in the sanatorium, he is the responsibility of the sanatorium physician who becomes his patient's instructor in health problems. Only as the patient understands the character of the disease that he is fighting will he know why it is necessary for him to follow closely a definite program, foregoing seemingly harmless pleasures and avoiding undue activity.

An understanding of the tuberculosis hospital will help the private physician in preparing his patient for treatment there. It will also enable him to give more effective counsel when the patient returns from the hospital. The need of periodic check-ups persists in all "cured" cases of tuberculosis even after economic independence and normal life has been attained.

The patient whose cooperation is enlisted at the time of the diagnosis is apt to become a good hospital patient. Moreover, such patients usually not only do better under treatment but are more successful in staying well after discharge. The foundation for successful treatment in tuberculosis is laid when the doctor tells the patient that he has the disease. Psychologically, medically and economically, this may well prove to be the biggest moment in the patient's life.

The Psychological Moment in the Treatment of Tuberculosis, J. D. Riley, M.D., American Review of Tuberculosis, October-November, 1946.

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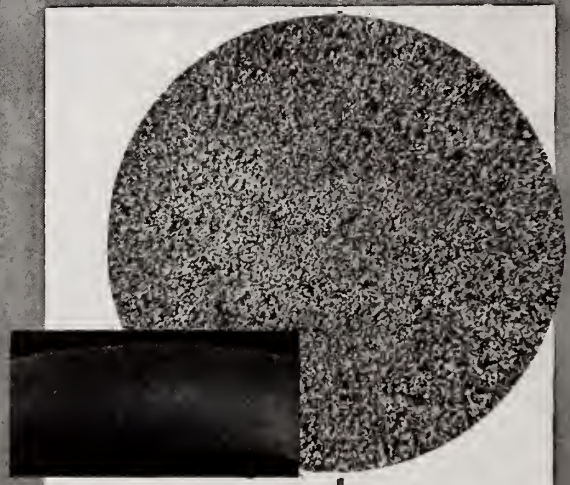
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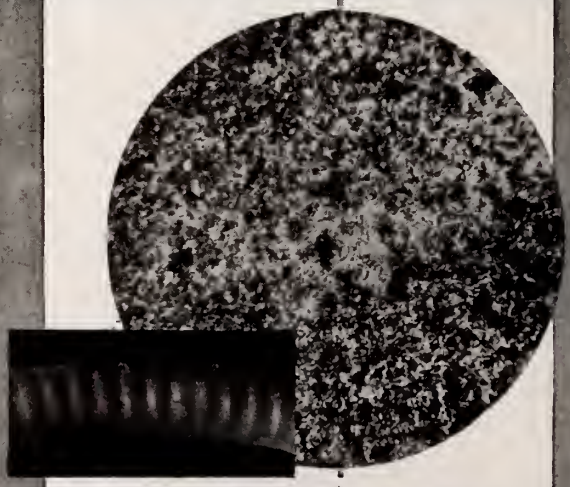
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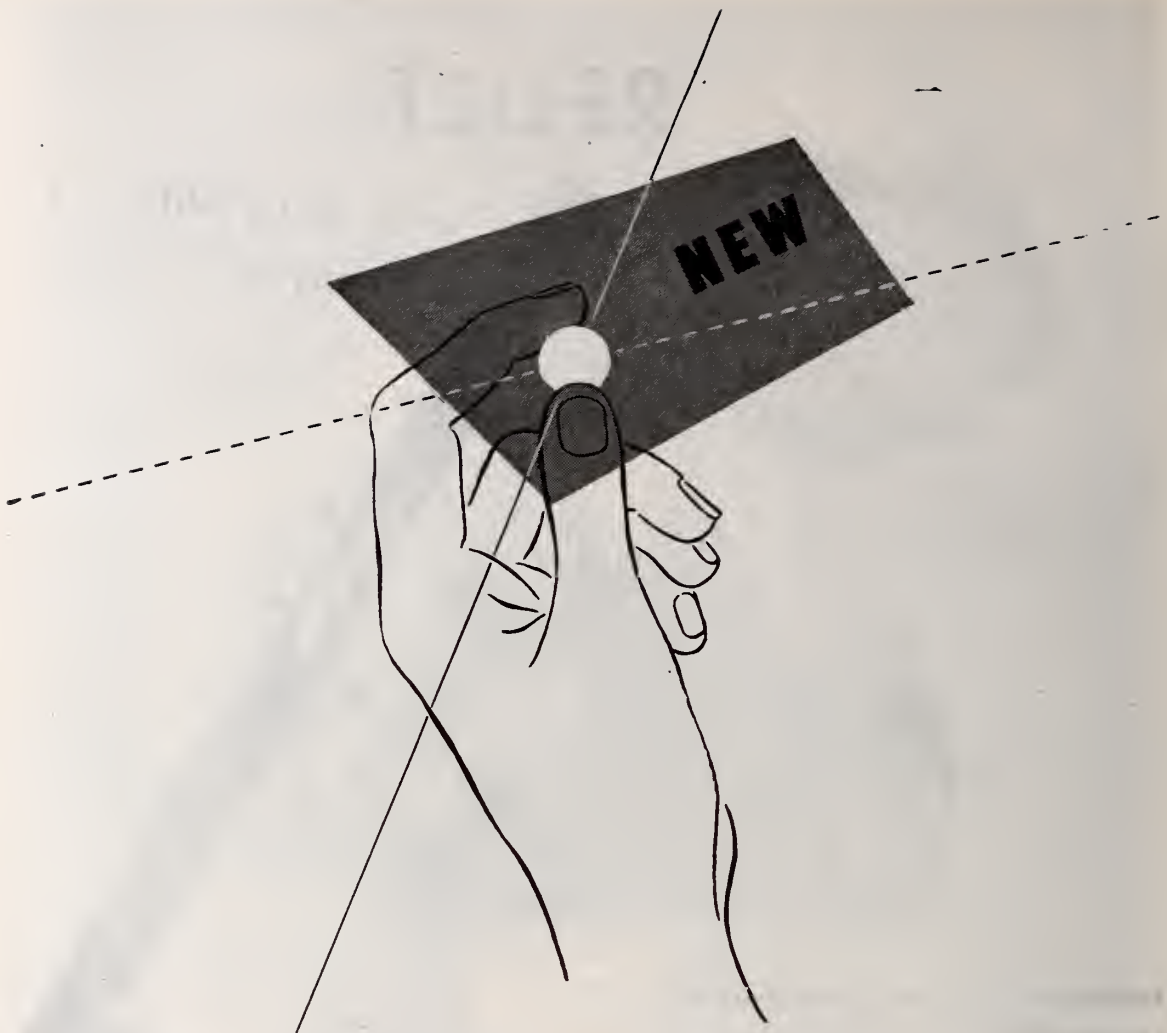
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JANUARY 13, 14 AND 15, 1947

MONDAY, JANUARY 13

Morning Session

New Drugs for Allergic Disorders ..... John L. Fromer
Rheumatic Infections ..... Frank P. Foster
Sterility ..... A. Seymour Parker
Hyperthyroidism and Its Complications ..... Lewis M. Hurxthal
Drug Therapy for Hyperthyroidism ..... Elmer C. Bartels
Thyroid Surgery ..... Frank H. Lahey

Luncheon—Round-table Discussion.
Questions and Answers on Endocrinology.

Afternoon Session

New Developments in Endocrinology ..... Lewis M. Hurxthal
New Developments in Hematology ..... John W. Norcross
Hoarseness ..... Walter B. Hoover
Diabetes ..... Frank N. Allan
Anal Fissure and Fistula ..... Neil W. Swinton
Carcinoma of the Breast ..... Samuel F. Marshall
Carcinoma of the Pancreas ..... Richard B. Cattell

TUESDAY, JANUARY 14

Morning Session

Surgery of the Esophagus ..... Ralph Adams
Liver Function and Liver Disorders ..... S. Allen Wilkinson
Inflammatory Lesions of the Intestine ..... Everett D. Kiefer
Malignant Lesions of the Intestine ..... Richard B. Cattell
Present Status of Peptic Ulcer ..... Sara M. Jordan
Carcinona of the Stomach ..... Samuel F. Marshall
Biliary Tract Disease ..... Frank H. Lahey

Luncheon—Round-table Discussion.
Questions and Answers on Gastroenterology.

Afternoon Session

Symposium on Headache and Pain in the Head, Neck, Shoulders. Back and Extremities....John B. Dynes, Gilbert Horrax, Kenneth Livingston, James W. Toumey, Frank D. Lathrop and G. E. Haggart.
Tumors, Cysts and Sinuses of the Neck ..... Frank H. Lahey

WEDNESDAY, JANUARY 15

Morning Session

Bacterial Endocarditis ..... Stewart H. Jones
Congenital Heart Disease ..... David I. Rutledge
Medical Treatment of Bronchial Infections ..... Carlton R. Souders
Surgery of Bronchiectasis ..... Ralph Adams
Tumors of the Lung and Mediastinum ..... Herbert D. Adams
Hypertension ..... James A. Evans
The Surgical Treatment of Hypertension ..... James L. Poppen

Luncheon—Round-table Discussion.
Questions and Answers on Diseases of the Lungs and Circulation.

Afternoon Session

Coma and Convulsions ..... Frank N. Allan
Radiation Therapy ..... Hugh F. Hare
Urinary Tract Infections ..... Earl E. Ewert
Office Treatment in Gynecology ..... Bentley P. Colcock
New Developments in Anesthesia .....
Urban H. Eversole, Morris J. Nicholson, Edward N. Allen
Anesthesia from the Surgeon's Standpoint ..... Frank H. Lahey

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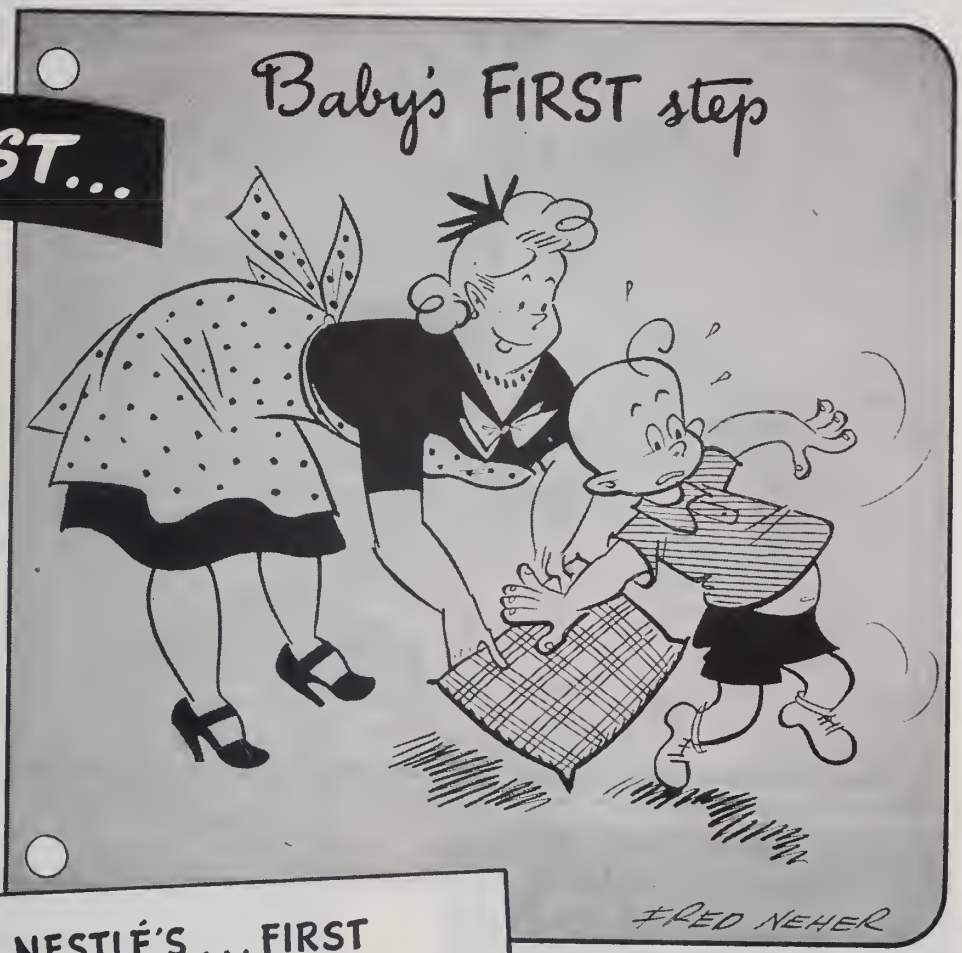
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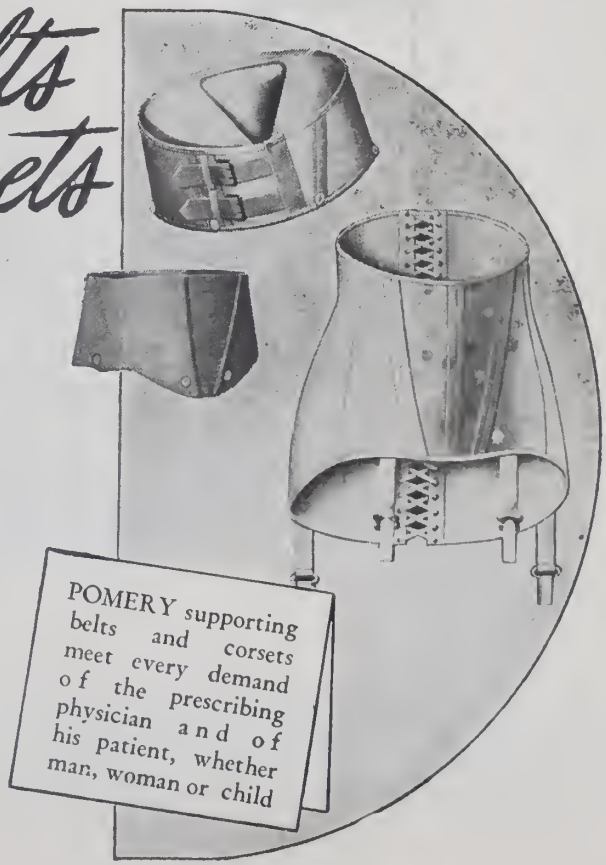
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Fortunately, extreme cases of rickets such as the one above illustrated are comparatively rare nowadays, due to the widespread prophylactic use of vitamin D recommended by the medical profession.

One of the surest and easiest means of routinely administering vitamin D (and vitamin A) to children is MEAD'S OLEUM PERCOMORPHUM WITH OTHER FISH-LIVER OILS AND VIOSTEROL. Supplied in 10-cc. and 50-cc. bottles. Also supplied in bottles of 50 and 250 capsules. Council Accepted. All Mead Products Are Council Accepted. Mead Johnson & Company, Evansville 21, Ind., U.S.A.

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OFFICIAL LIST

of

Fellows and Members

of

The Medical Society of New Jersey

March 1, 1946

Supplement to The Journal of The Medical Society of New Jersey, April, 1946

Supplement to The Journal of The Medical Society of New Jersey, April, 1946

OFFICIAL LIST OF MEMBERS

OF

THE MEDICAL SOCIETY OF NEW JERSEY

FOR THE YEAR 1946

FELLOWS

"THE FELLOWS ARE THE EX-PRESIDENTS OF THE SOCIETY." (Constitution, Article IV. Section 2-a)

Year of Election

1. 1766—Robert McKean, Perth Amboy, 1732-1767
2. 1767—William Burnet, Newark, 1730-1791
3. 1768—John Cochran, New Brunswick, 1730-1807
   1769—John Cochran, No. 3, reëlected
4. 1770—Nathaniel Scudder, Freehold, 1733-1781
5. 1771—Isaac Smith, Trenton, 1740-1807
6. 1772—James Newell, Freehold, 1725-1791
7. 1773—Absalom Bainbridge, Lawrenceville, 1742-1807
8. 1774—Thomas Wiggins, Princeton, 1731-1801
9. 1775—Hezekiah Stites, Cranbury, 1726-1790

No formal meetings 1776-1780 on account of the War of the Revolution.

1781—James Newell, No. 6, reëlected

10. 1782—John Beatty, Trenton, 1749-1826
11. 1783—Thomas Barber, Matawan, 1730-1807
12. 1784—Lawrence Vander Veer, Roycefield, 1740-1815
13. 1785—Moses Bloomfield, Woodbridge, 1729-1791
    1786—William Burnet, No. 2, reëlected
14. 1787—Jonathan Elmer, Bridgeton, 1745-1817
15. 1788—James Stratton,. Swedesboro, 1755-1812
16. 1789—Moses Scott, New Brunswick, 1738-1821
17. 1790—John Griffith, Rahway, 1736-1805
18. 1791—Lewis Dunham, New Brunswick, 1754-1821
19. 1792—Isaac Harris, Middlesex County, 1741-1808

No elections held in 1793 and 1794 because quorum not present.

20. 1795—Elisha Newell, Allentown, 1755-1799

No formal meetings 1796-1806 owing to an attempt to establish a rival society in Eastern New Jersey.

21. 1807—Jonathan F. Morris, Somerville, 1760-1810
22. 1808—Peter I. Stryker, Somerville, 1766-1859
23. 1809—Lewis Morgan, Rahway, 1757-1821
24. 1810—Lewis Condict, Morristown, 1773-1862
25. 1811—Charles Smith, New Brunswick, 1768-1848
26. 1812—Matthias H. Williamson, Elizabeth
    1813—Matthias H. Williamson, continued for second year
27. 1814—Samuel Forman, Freehold, 1764-1845
28. 1815—John Van Cleve, Princeton, 1778-1826
    1816—Lewis Dunham, No. 18, reëlected
    1817—Peter I. Stryker, No. 22, reëlected
    1818—John Van Cleve, No. 28, reëlected
    1819—Lewis Condict, No. 24, reëlected
29. 1820—James Lee, Newark
30. 1821—William G. Reynolds, Manalapan

Year of Election

31. 1822—Augustus R. Taylor, Somerville, 1782-1840
32. 1823—William B. Ewing, Greenwich, 1776-1866
    1824—Peter I. Stryker, reëlected. Also served 1808 and 1817.
33. 1825—Gilbert S. Woodhull, Manalapan, 1794-1830
34. 1826—William D. McKissack, Millstone, 1781-1853
35. 1827—Isaac Pierson, Orange, 1770-1833
36. 1828—Jephtha B. Munn, Chatham, 1780-1863
37. 1829—John W. Craig, Somerset County, 1795-1871
    1830—Augustus R. Taylor, No. 31, reëlected
38. 1831—Thomas Yarrow, Sharptown, 1778-1841
39. 1832—E. FitzRandolph Smith, New Brunswick, 1786-1865
40. 1833—William Forman, Monmouth County. 1796-1848
41. 1834—Samuel Hayes, Newark, 1776-1839
42. 1835—Abraham P. Hagerman, Somerset County
43. 1836—Henry Vander Veer, Somerville, 1792-1874
44. 1837—Lyndon A. Smith, Newark, 1795-1865
45. 1838—Benjamin H. Stratton, Mt. Holly, 1804-1875
46. 1839—Jabez G. Goble, Newark, 1799-1859
47. 1840—Thomas P. Stewart, Hackettstown, 1798-1846
48. 1841—Ferdinand S. Schenck, Six Mile Run, 1790-1860
49. 1842—Zachariah Read, Mt. Holly, 1808-1879
50. 1843—Abraham Skillman, Bound Brook, 1796-1862
51. 1844—George R. Chetwood, Elizabeth, 1802-1885
52. 1845—Robert S. Smith, Bound Brook, 1800-1874
53. 1846—Charles Hannah, Deerfield, 1782-1857
54. 1847—Jacob T. B. Skillman, Woodbridge, 1794-1864
55. 1848—Samuel Hayes Pennington, Newark, 1806-1900
56. 1849—Joseph Fithian, Woodbury, 1795-1881
57. 1850—Elias J. Marsh, Paterson, 1803-1850
58. 1851—John H. Phillips, Pennington, 1814-1878
59. 1852—Othnell H. Taylor, Camden, 1803-1869
60. 1853—Samuel Lilly, Lambertville, 1815-1880
61. 1854—Alfred B. Dayton, Middletown Point, 1812-1870
62. 1855—James B. Coleman, Trenton, 1806-1877
63. 1856—Richard M. Cooper, Camden, 1816-1874
64. 1857—Thomas Ryerson, Newton, 1821-1887
65. 1858—Isaac Pierson Coleman, Pemberton, 1804-1869
66. 1859—John R. Sickler, Mantua, 1800-1886
67. 1860—William Elmer, Bridgeton, 1814-1889

Year of Election

68. 1861—John Blane, Perryville, 1802-1885
69. 1862—John Woolverton, Trenton, 1825-1888
70. 1863—Theodore R. Varick, Jersey City, 1825-1887
71. 1864—Ezra M. Hunt, Metuchen, 1830-1894
72. 1865—Abraham Coles, Newark, 1813-1891
73. 1866—Benjamin R. Bateman, Bridgeton, 1807-1883
74. 1867—John C. Johnson, Blairstown, 1828-1907
75. 1868—Thomas J. Corson, Trenton, 1828-1879
76. 1869—William Pierson, Orange, 1796-1882
77. 1870—Thomas F. Cullen, Camden, 1822-1877
78. 1871—Charles Hasbrouck, Hackensack, 1818-1877
79. 1872—Franklin Gauntt, Burlington, 1823-1900
80. 1873—Thomas J. Thomason, Perrineville, 1833-1880
81. 1874—George H. Larison, Lambertville, 1831-1892
82. 1875—William O'Gorman, Newark, 1824-1887
83. 1876—John V. Schenck, Camden, 1825-1882
84. 1877—Henry R. Baldwin, New Brunswick, 1829-1902
85. 1878—John S. Cook, Hackettstown, 1827-1900
86. 1879—Alexander W. Rogers, Paterson, 1814-1905
87. 1880—Alexander N. Dougherty, Newark, 1822-1882
88. 1881—Lewis W. Oakley, Elizabeth, 1828-1888
89. 1882—John W. Snowden, Blackwood, 1823-1888
90. 1883—Stephen Wickes, Orange, 1813-1889
91. 1884—Phanett C. Barker, Morristown, 1835-1903
92. 1885—Joseph Parrish, Burlington, 1818-1891
93. 1886—Charles J. Kipp, Newark, 1838-1911
94. 1887—John W. Ward, Trenton, 1840-1916
95. 1888—H. Genet Taylor, Camden, 1837-1916
96. 1889—Beriah A. Watson, Jersey City, 1836-1892
97. 1890—James S. Green, Elizabeth, 1829-1892
98. 1891—Elias J. Marsh, Paterson, 1835-1908
99. 1892—George T. Welch, Passaic, 1845-1924
100. 1893—John G. Ryerson, Boonton, 1834-1916
101. 1894—Obadiah H. Sproul, Flemington, 1844-1925
102. 1895—William Elmer, Trenton, 1840-1908
103. 1896—Thomas J. Smith, Bridgeton, 1841-1932
104. 1897—David C. English, New Brunswick, 1842-1924
105. 1898—Claudius R. P. Fisher, Bound Brook, 1859-1927
106. 1899—Luther M. Halsey, Williamstown, 1858-1921
107. 1900—William Pierson, Jr., Orange, 1830-1900
108. 1901—John D. McGill, Jersey City, 1846-1912
109. 1902—Edward L. B. Godfrey, Camden, 1850-1913
110. 1903—Henry Mitchell, Asbury Park, 1845-1919
111. 1904—Walter B. Johnson, Paterson, 1852-1922
112. 1905—Henry W. Elmer, Bridgeton, 1847-1907
113. 1906—Alexander Marcy, Jr., Riverton, 1860-1934
114. 1907—Edward J. Ill, Newark, 1854-1942

Year of Election

115. 1908—David St. John, Hackensack, 1850-1917
116. 1909—Benjamin A. Waddington, Salem, 1842-1917
117. 1910—Thomas H. MacKenzie, Trenton, 1847-1920
118. 1911—David Strock, Camden, 1850-1927
119. 1912—Norton L. Wilson, Elizabeth, 1861-1931
120. 1913—Enoch Hollingshead, Pemberton, 1843-1924
121. 1914—Frank D. Gray, Jersey City, 1857-1916
122. 1915—William J. Chandler, South Orange, 1842-1927
123. 1916—Philip Marvel, Atlantic City, 1856-1938
124. 1917—William G. Schauffler, Lakewood, 1862-1933
125. 1918—Thomas W. Harvey, Orange, 1853-1938
126. 1919—Gordon K. Dickinson, Jersey City, 1855-1930
127. 1920—Philander A. Harris, Paterson, 1852-1924
128. 1921—Henry B. Costill, Trenton, 1860-1935
129. 1922—James Hunter, Jr., Westville, 1866-1931
130. 1923—**WELLS P. EAGLETON**, Newark, born 1865
131. 1924—Archibald Mercer, Newark, 1849-1931. Resigned.
1924—**LUCIUS F. DONOHOE**, Acting President
132. 1925—**LUCIUS F. DONOHOE**, Bayonne, born 1868
133. 1926—James S. Green, Jr., Elizabeth, 1864-1936
134. 1927—Walt P. Conaway, Atlantic City, 1873-1945
135. 1928—Ephraim R. Mulford, Burlington 1880-1939
136. 1929—Andrew F. McBride, Paterson, 1869-1946
137. 1930—**GEORGE N. J. SOMMER**, Trenton, born 1874
138. 1931—John F. Hagerty, Newark, 1869-1937
139. 1932—A. Haines Lippincott, Camden, 1867-1937
140. 1933—**FREDERIC J. QUIGLEY**, Union City, born 1883
141. 1934—**LANCELOT ELY**, Somerville, born 1875
142. 1935—**MARCUS W. NEWCOMB**, Browns Mills, born 1880
143. 1936—Francis R. Haussling, Newark, 1875-1941 —resigned
144. 1936—**SPENCER T. SNEDECOR**, Hackensack, born 1900
145. 1937—**WILLIAM G. HERRMAN**, Asbury Park, born 1890
146. 1938—**WILLIAM J. CARRINGTON**, Atlantic City, born 1884
147. 1939—**E. ZEH HAWKES**, Newark, born 1865
148. 1940—**WATSON B. MORRIS**, Springfield, born 1878
149. 1941—**THOMAS K. LEWIS**, Camden, born 1887
150. 1942—Elias J. Marsh, Paterson, 1875-1943
151. 1943—**RALPH K. HOLLINSHED**, Westville, born 1884
152. 1944—**JOSEPH F. LONDRIGAN**, Hoboken, born 1884
153. 1945—**SAMUEL ALEXANDER**, Park Ridge, born 1888

The names of living Fellows are in bold face type.

HONORARY MEMBERS

Year of Election

1. 1930—Joseph E. Raycroft, Princeton
2. 1935—Wells P. Eagleton, Newark
3. 1939—Nathan V. Van Etten, New York

Year of Election

4. 1939—Haven Emerson, New York
5. 1945—Lucius F. Donohoe, Bayonne

An Alphabetical List of the Members of The Medical Society of New Jersey

COMPILED MARCH 1, 1946

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

Bold face type indicates members in service

A

ACTIVE MEMBERS

Abbamonte, Louis W. (7)
Abel, Arthur R. (7)
Abel, Henri E. (20)
Abey, William J. H. (11)
Abrams, Abram B. (7)
Abramson, Solomon (20)
Achtentuch, Herman (16)
Ackerhalt, Martin J. (16)
Ackerman, Arthur F. (20)
Ackley, David B. (11)
Adams, Rayford K. (18)
Adelman, Benjamin B. (7)
Adelman, Nathan (7)
Adler, Fritz F. (16)
Adler, Howard E. (12)
Adler, Hubert J. (21)
Africano, Julius V. (9)
Agayoff, John D. (2)
Agnew, Hobart M. (7)
Agolia, Michael W. (9)
Ainsley, H. Bryson (9)
Aitken, Frank J. (6)
Aitken, Herbert M. (19)
Albano, Edwin H. (7)
Albano, Frank J. (7)
Albano, Joseph (7)
Albert, Perry (11)
Albright, Louis F. (13)
Alcaro, Joseph A. (14)
Alexander, Samuel (2)
Alexander, Stewart F. (2)
Alexander, Walter G. (7)
Alford, Ralph I. (7)
Allan, James S. (7)
Allegrante, Anthony J. (18)
Allen, Arthur A. (16)
Allen, Chester B., Jr. (7)
Allen, Edwin J. (16)
Allen, James M. (16)
Allen, Raymond N. (7)
Allen, Samuel L. (20)
Alling, Frederic A. (7)
Allman, David B. (1)
Alpert, Edward (9)
Alpren, Bernard F. (16)
Alter, Nicholas M. (9)
Altman, Charles D. (7)
Altschul, Frank J. (13)
Ambrose, Anthony (7)
Ambrose, Robert R. (18)
Amdur, Louis A. (9)
Anastor, Herbert C. (6)
Anderson, Ethelyn J. C. (2)
Anderson, John F. (12)
Anderson, Reuben M. (2)
Anderson, Richard D. (3)
Anderson, Robert C. (7)
Anderson, William A. (7)
Anderson, William M. (4)
Andrews, Albert G. K. (16)
Andrews, Clarence L. (1)
Andrews, Thomas H. (13)
Andrus, David L. (4)
Angelillis, Paul (2)
Angelillo, Marc C. (7)
Angelo, Joseph A. (9)
Angioletti, Louis V. (2)
Angus, Leslie R. (4)
Annitto, John E. (9)
Anrig, Grace E. (9)
Anson, Leon J. (20)
Anthony, David W. (11)
Antonius, Nicholas A. (7)
Antopol, William A. (7)
Anuario, Charles B. (7)
Apfelbaum, Frederick M. (20)
Applebaum, Irving L. (7)
Applegate, Edward T. R. (11)
Applestein, Robert (11)
Appleton, Ralph (15)
Appold, George D. (2)
Apter, Abraham H. (16)
Arbeit, Sidney R. (9)
Arena, John (9)
Areson, William H. (7)
Aria, Charles J. (9)
Aria, Michael H. (9)
Armstrong, Lorrimer B. (20)
Arndt, Frank R. (9)
Aronis, Harry R. (11)
Aronowitz, Harry T. (9)
Arons, Harry (7)
Artaserse, George V. (9)
Arthur, Frances H. (20)
Asbell, Nathan (4)
Ash, Arthur F. (9)
Ash, Frank W. (16)
Ash, Samuel (7)
Asher, Maurice (7)
Ashley, Harmon H. (11)
Assante, M. Hugo (4)
Aszody, Paul (7)
Athey, Kenneth L. (4)
Atkinson, James Q. (3)
Atkinson, John M. (14)
Atwood, Edward A. (16)
Auerbach, Friedrich (7)
Auriemma, Michele (9)
Austin, Henry J. (11)
Austin, Thomas R. (20)
Averbach, Jacob (16)
Avery, Philip S. (12)
Axilrod, Maurice H. (1)

ASSOCIATE MEMBERS

Adalson, Edward (7)
Adler, Lydia (12)
Alexander, John W. (7)
Alpert, Sidney (15)
Amato, John R. (7)
Audi, Eugene H. (2)
Autorino, Ralph R. (7)

B

ACTIVE MEMBERS

Babbitt, Hugh M., Jr. (20)
Bachmann, William (7)
Bacon, Mary (6)
Bacote, Ernest F. (7)
Baeseman, R. Winfield (13)
Bagg, Linus W. (7)
Bahnson, Conrad M. (9)
Ballyn, Emanuel (9)
Balme, Jules E. (7)

Baiocchi, Pascal J. (7)
Baird, Thompson M. (7)
Baker, Augustus L. (14)
Baker, Banks S. (4)
Baker, Elsworth F. (13)
Baker, Hugh W. (6)
Baker, Maclyn F. (7)
Baker, Maurice E. (4)
Baker, Philip W. (10)
Baker, Raymond D. (20)
Baketel, H. Sheridan (2)
Baldauf, Herman, Jr., (21)
Baldwin, John F. (2)
Baldwin, Samuel H. (7)
Balis, Samuel B. (7)
Ballard, William C. (14)
Balles, Edward S. (16)
Ballinger, Reeve L. (9)
Balogh, William A. (12)
Balsamo, Anthony J. (9)
Balsamo, Joseph J. (7)
Balson, Zachary D. B. (7)
Balze, Henry R. (2)
Bambara, Aurelius J. (10)
Banker, George T. (20)
Banta, Raymond E. (2)
Bar, Samuel (13)
Barb, Kirk B. (4)
Barbano, Alfred J. (12)
Barbarito, William N. (9)
Barbash, Roslyn H. W. (2)
Barbash, Samuel (1)
Barbella, Joseph D. (7)
Barberio, A. Arthur (20)
Barbour, George E. (18)
Barkhorn, Charles W. (7)
Barkhorn, Henry C. (7)
Barlow, Frank A. (16)
Barlow, G. Barton (2)
Barlow, John D. (11)
Barnard, Frank G. (7)
Barnes, William J. (2)
Barnett, Lester A. (13)
Barnshaw, Harold D. (4)
Barolsky, Benjamin (16)
Baron, Herbert A. (2)
Baron, Leo E. (20)
Barone, Francis A. (9)
Barr, Joseph (16)
Barrett, John E. (7)
Barrett, Joseph F. (7)
Barroway, James N. (4)
Barrows, Arthur M. (11)
Barry, R. Grant (11)
Bartlett, Clara K. (1)
Bartolini, Frank (21)
Barton, Amy S. (3)
Baruch, Hilde (20)
Baruch, Rudolf J. (20)
Basralian, Joseph B. (2)
Bass, Rose D. (7)
Bassett, Lavern C. (12)
Bassett, Norman H. (1)
Battaglia, Richard S. (20)
Baum, Felix (7)
Baum, Lewis F. (7)
Baum, Samuel (7)
Bauman, Everett O. (7)
Bauman, Rush C. (7)
Baxt, Sidney J. (16)
Bayne, Joseph K. (11)
Beairsto, Everett B. (11)
Beatty, Hannah J. (10)
Beaver, Jennie D. (14)
Bechet, Paul E. (20)
Becker, C. Frederick (4)
Becker, Frank F. (16)
Becker, George L. (16)
Becker, Leo V. (16)
Becker, Martin (7)
Becker, Sidney D. (13)
Bedrick, John J. (9)
Beer, Sanel (7)
Beideman, Casper M. (4)
Beir, Ily R. (1)
Beisler, Lawrence G. (20)
Belafsky, Henry A. (12)
Belfer, Jacob J. (11)
Belford, Ralph J. (11)
Beling, C. Abbott (7)
Beling, Christopher C. (7)
Bell, Horace O. (7)
Bell, Thomas (7)
Bellak, Ellis R. (6)
Bellis, Horace D. (11)
Belott, Louis Y. (7)
Ben-Asher, Solomon (9)
Bender, Dorothea A. (20)
Bender, Louis (7)
Bender, Theodore (16)
Bengelsdorf, Aron (7)
Benjamin, Harold C. (9)
Benjamin, Joseph F. (16)
Bennett, Robert E. (11)
Bensley, Maynard G. (20)
Bentley, David F., Jr. (4)
Benz, Francis J. (14)
Berardinelli, Carmine G. (7)
Berenson, Samuel J. (20)
Beres, Albert J. (2)
Berg, Samuel (7)
Berger, William A. (7)
Bergin, Joseph V. (16)
Bergman, Meyer W. (7)
Bergmann, Ewald H. (19)
Bergsma, Daniel (11)
Berk, M. David (16)
Berke, Raynold N. (2)
Berkhout, Peter G. (16)
Berkow, Samuel G. (12)
Berkowitz, Benjamin (6)
Berlin, Joseph I. (9)
Berlin, Morris R. (7)
Berman, H. Robert (7)
Berman, Jacob J. (11)
Berman, Leonard M. (20)
Berman, Sol (20)
Bernard, Richard C. (2)
Berney, Irving (7)
Berney, Ruth V. (7)
Bernhard, William G. (7)
Bernheisel, Louis E. (5)
Bernson, Samuel T. (16)
Bernstein, Arthur (7)
Bernstein, Benedict J. (20)
Bernstein, Bertram (11)
Bernstein, Julius (7)
Berry, C. Hartley (20)
Berry, Leonard M. (11)
Bertha, Nicholas A. (14)
Beshlian, Hagop K. (16)
Besson, Franklin J. (7)
Betancourt, Raul R. (4)
Betcher, Albert M. (9)
Betts, R. Winfield (3)
Bew, Richard C. (1)
Beyer, Othmar J. (7)
Beyer, William (2)
Bianchi, Angelo R. (7)
Bianco, John J. (4)
Biber, David (20)
Biczak, Arkad K. (16)
Bierach, Jules L. (15)
Bigelow, Nelson S. (7)
Bigliani, Urban R. (9)
Binder, Charles I. (7)
Binder, Joseph (13)
Bird, Frank L. (14)
Birdsall, Clarence A. (7)
Birrell, Russell G. (20)
Bishop, Carl (20)
Bissett, John V. (7)
Biunno, Anthony J. (7)
Black, LeRoy W. (2)
Black, Maskell B., (8)
Black, Max S. (20)
Blackburne, George (7)
Blackwell, Enoch (11)
Blair, Thomas D. (20)
Blaisdell, C. Byron (13)
Blake, Albert J. (16)
Blakey, Abram P. (9)
Blanchard, Charles L. (14)
Blanchard, Kenneth (7)
Blank, Samuel (18)
Blatt, David (20)
Blaugrund, Samuel (11)
Blaustein, Maurice L. (7)
Blauvelt-Wells, Grace B. (2)
Bleasby, Charles B. (2)
Bleiberg, Jacob (7)
Blenkle, Victor A. (2)
Bloch, Harry (20)
Block, Marcus T. (7)
Block, Max (7)
Block, Milton (7)
Bloom, G. Homer (21)
Blum, Milton (9)
Blumberg, Jack (20)
Blythe, Rowland P. (20)
Bobadilla, Juan E. B. (14)
Bocchini, Joseph A. (7)
Boehm, Herbert (20)
Bohl, Louis J. (16)
Bokor, Emery (7)
Bolanowski, Kasimier J. (20)
Bolten, Bernard (7)
Bongiorno, Henry D. (16)
Bonnet, W. Laurence (11)
Bono, Joseph J. (2)
Bonomo, Michael J. (7)
Bookrajian, Edward N. (9)
Bookstaver, Barnet S. (2)
Booth, George R. (8)
Booth, Herbert W. (13)
Booth, Walter S. (20)
Booth, William K. (14)
Boquist, Walter A. (21)
Bornstein, David (16)
Bornstein, Paul K. (13)
Borow, Henry (18)
Borow, Louis S. (18)
Borow, Maurice (18)
Borrella, Dominic D. (11)
Borrone, Milton G. (9)
Borshaw, Hyman (9)
Borsher, Irving P. (7)
Bortone, Frank (9)
Bosch, Taeke (2)
Boselli, Emile H. (9)
Bossard, Harry B. (21)
Bossone, Joseph E. (13)

Bostwick, Delazon S. (6)
Bostwick, Wallace R. (21)
Botbyl, Burt W. (16)
Botti, John A. (9)
Bourns, Edward G. (20)
Bove, Joseph (7)
Bowen, Robert N. (4)
Bowers, F. Clyde (14)
Bowersox, Clarence A. (8)
Bowles, Harry H. (20)
Bowman, Ned O. (12)
Boyd, John B. (13)
Boyd, Robert P. (20)
Boyd, William B., Jr. (19)
Boyer, Charles G. (10)
Boyer, Paul K. (20)
Boyers, Sidney S. (9)
Boyes, James G. (20)
Boylan, Lawrence B. (16)
Boyle, Francis L. (9)
Brackett, Elizabeth R. (7)
Bradasch, George A. (9)
Bradford, Stella S. (7)
Bradley, Robert A. (1)
Brady, Thomas S. (9)
Braitman, Max (9)
Bramble, Halsey S. (17)
Brams, William M. (7)
Brancato, Peter (16)
Brancone, Alphonse M. (16)
Brandman, Otto (7)
Branin, Howard S. (6)
Branon, Mark E. (2)
Brasefield, Edgar N. (21)
Brauer, Selig L. (9)
Braun, David C. (19)
Braun, Edgar M. (20)
Braun, Gustav A. (7)
Braun, Joseph C. (2)
Braun, William (4)
Braunstein, Sigmund C. (9)
Braunstein, William P. (9)
Braunwarth, Robert J. (20)
Bray, William E. (3)
Bregman, Alexander (2)
Bregman, Milton (13)
Breitstadt, Charles A. (7)
Bremer, Kenneth M. (7)
Brennan, Alfred T. V., Jr. (2)
Brennan, Charles L. S. (4)
Brennan, John P. **(4)**
Brenneman, Richard E. (4)
Brennock, Thomas McG. (9)
Bresey, Morris (9)
Breslow, Alexander E. (20)
Breslow, Samuel (12)
Brethwaite, Samuel H., Jr. (20)
Brewer, David R., Jr. (8)
Brick, George J. (9)
Brien, William M. (7)
Briggs, Henry (7)
Brignola, Gerald C. (9)
Brim, Anne S. (7)
Brindle, Harry R. (13)
Brittain, Elmore G. (18)
Broadnax, Mary E. (7)
Brodkin, Eva T. (7)
Brodkin, Henry A. (7)
Brody, Morton S. (12)
Brogan, Francis B. (16)
Brokaw, Christopher A. (20)
Bromberg, Charles B. (16)
Bronner, Alfred (16)
Brooke, Charles R. (7)
Brooks, Clyde (7)
Brooks, George M. (5)
Brooks, Sidney S. (16)
Brophy, Francis X. (9)
Broselow, Benjamin G. (8)
Brotman, Harry (7)
Brotman, Morton M. (7)
Brown, Chester R. (7)
Brown, Chester T. (7)
Brown, Edward V. (7)
Brown, Frank H., Jr. (20)
Brown, Harold W. (7)
Brown, J. Carlisle (1)
Brown, John L. (2)
Brown, Kenneth G. (13)
Brown, L. Greeley (20)
Brown, Leonard (2)
Brown, Lewis W. (7)
Brown, Stanley L. (4)
Brown, William H. (20)
Browne, George F. (7)
Browning, William J. (4)
Brozdowski, John J. (9)
Brozyna, Mieczyslaw (2)
Bruning, Richard H. (7)
Brunkow, Charles D. (7)
Buchanan, Ralph M. L. (21)
Buchanan, Robert W. (20)
Buckley, Jeremiah L. (7)
Buckley, Paul J. (2)
Buckley, Richard T., Jr. (11)
Buckner, Roscoe W. H. **(7)**
Budd, J. Reuben **(16)**
Buermann, August, III (7)
Buermann, Robert **(15)**
Buffey, Walter H. (20)
Bull, Louis M. (7)
Bull, William J. (7)
Bullen, Victor E. **(16)**
Bump, Samuel C. (2)
Bunnell, Frederick N. **(15)**
Burbidge, J. Raymond (11)
Burke, Leonard P. (7)
Burke, Stephen E. (7)
Burkett, J. Paul (8)
Burkett, Wendell J. (8)
Burkhead, Howard C. (13)
Burn, Victor E. (19)
Burne, John J. (7)
Burnham, Lyman (2)
Burns, Geoffrey C. H. (2)
Burns, Joseph R. (11)
Burns, Wilmer F. (4)
Burpeau, William P. (7)
Burrill, Benjamin B., Jr. (7)
Burritt, Norman W. (20)
Burroughs, Edmund W. (11)
Burstein, Frank (7)
Burstein, Leo Q. (7)
Burstein, Rachel (7)
Busansky, Samuel T. (3)
Busch, Herman (7)
Bush, Archer C. (7)
Bush, Ralph K. (4)
Busicco, Philip S. (2)
Butan, Louis (7)
Butcher, Charles (6)
Butenas, Joseph J. (20)
Butler, Samuel S. (4)
Butler, Vincent P. (9)
Butterfield, Arey A. (16)
Buvinger, Charles W. (7)
Byck, Louis (7)
Byer, M. Yale (11)
Byrne, J. Arthur (14)
Byrnes, Elizabeth W. (7)
Bythewood, Alton E., Jr. (7)

ASSOCIATE MEMBERS

Baer, Irving (13)
Bassett, Samuel (2)
Bayer, Eric C. (2)
Block, Charles (7)
Boyd, James W. (7)
Brady, Frank J. (7)
Brandchaft, Bernard **(7)**
Brezinski, Edward J. **(12)**

C

ACTIVE MEMBERS

Cacciarelli, Robert A. (7)
Caggiano, Anthony P. (7)
Caggiano, John D. (17)
Cahill, Laurence A. (7)
Calabrese, D. John (2)
Calasibetta, Charles J. (7)
Caldwell, Donald M. (7)
Caldwell, Julius A. (7)
Calcca, Jack J. (19)
Callahan, Edward J. (20)
Calligaro, Egildo A. (16)
Calvert, William C. (7)
Calvin, Charles H. (12)
Camche, Leo J. (7)
Cameron, Arthur E. (7)
Cameron, C. Paul (5)
Cameron, Edwin A. (7)
Campana, Vincent R. (9)
Campbell, Everette L. (7)
Campbell, James M. (2)
Campbell, William (7)
Campo, A. Guy (8)
Candio, Vincent P. (2)
Cangemi, Vito F. (9)
Cannis, John P. (20)
Cannon, Edward A. (9)
Canright, Cyril M. (20)

Cantalupo, Emidio (7)
Cantelmo, Alphonse L. (7)
Cantini, Raphael S. (20)
Capell, Harry H. (16)
Capio, Mario D. (16)
Caprio, Orlando G. (7)
Captanian, Aram A. (13)
Caputo, Anthony R. (7)
Carabelli, A. Albert (11)
Carbone, Francesco N. (7)
Carbone, Ralph (2)
Card, Charles F. (20)
Cardinale, Pasquale F. (20)
Cardwell, Edgar P. (7)
Carey, David S. (13)
Caridi, Salvatore (9)
Carlander, Oswald R. (4)
Carlin, Edward J. M. (20)
Carlisle, J. Mallory (20)
Carlisle, John H. (16)
Carlisle, Paul E. (7)
Carlough, David J. (16)
Carlucci, Angelo M. (18)
Carman, Fletcher F. (7)
Carmona, L. Roberto (15)
Carpenter, Cedric C. (20)
Carpenter, Charles A. (7)
Carpenter, William H. (8)
Carr, Josephus C. (7)
Carrigan, Francis P. (7)
Carrington, William J. (1)
Carrol, Wilfred (7)
Carroll, C. Walter (11)
Carroll, Thomas R. (2)
Carroll, William V. (11)
Carsley, Sidney H. (20)
Carter, Joseph F. S. (13)
Cartisser, Joseph J. (19)
Cartnick, Louis C. (2)
Caruso, Paul F. (2)
Casagrande, Stephen R. (13)
Casale, John B. (7)
Casciano, Adolph D. (2)
Casey, Robert B. (20)
Casilli, Arturo R. (20)
Casselman, Arthur J. (4)
Cassini, Henry C. (7)
Castaldo, Neil (20)
Castellano, Martin G. (7)
Catanzaro, Francesco (16)
Cella, Charles F. (11)
Cerone, Daniel M. (7)
Cerreto, Frank R. (7)
Cestone, Canio (7)
Cetrulo, Gerald I. (7)
Chaiken, Louis H. (20)
Chalfant, W. Paxson, Jr. (1)
Chalfant, William P. (8)
Chamberlain, Aims R. (7)
Chamberlain, Richard R. (7)
Champlin, Paul M. (7)
Chapman, Otis P. (20)
Chapman, Robert W. (7)
Chapman, Walter I. (16)
Chapnick, Maurice M. (16)
Charleroy, Durant K. (11)
Charlton, C. Coulter (1)
Charney, William (16)
Charnock, Maurice P. (11)
Chase, Kalman, Jr. (2)
Chattin, J. Franklin (7)
Chayes, Sydney (9)
Cherashore, Harry N. (7)
Chernus, Jack (7)
Cherry, Homer H. (16)
Cheskin, Louis J. (7)
Chesler, Maurice (17)
Chesner, William A. (11)
Chesnick, Reuben B. (4)
Chester, Saul W. (16)
Chianese, C. Chester (11)
Chiger, Alexander S. (7)
Childers, Robert J. (20)
Chilton, Forrest S. (16)
Chimacoff, Hyman (7)
Chmelnik, Abraham G. (7)
Chodosh, Maurice A. (20)
Choffy, Sylvester A. (9)
Chrisman, Irving (16)
Christian, Henry A. (9)
Christoph, Francis T. (7)
Churg, Jacob (16)
Ciampa, Ralph P. E. (13)
Ciccone, Anthony C. (16)
Ciccone, Edwin L. (7)
Cioffi, Eugene (21)
Citrino, Robert J. (7)
Clarie, D'Arcy C. (2)
Clark, Alice L. (11)
Clark, Ernest W. (4)
Clark, Frank G. (10)
Clark, John C. (13)
Clark, Margaret A. (2)
Clark, Orlo H. (16)
Clark, S. Worth (1)
Clarke, Edward W. (2)
Clarke, Francis M. (12)
Clarke, R. Manning (4)
Clarken, Joseph A. (7)
Cleary, Joseph P. (1)
Clement, Baxter L. (7)
Clement, John B. (3)
Clinton, Joseph A. (7)
Close, Byron H. (16)
Cloud, Albert W. (2)
Clunan, Ambrose P. (11)
Coburn, J. Wesley (7)
Coffin, Henry F. (7)
Cogan, Henry (16)
Coghlan, Jasper (7)
Cohan, Charles C. (11)
Cohan, Joseph (11)
Cohen, Herman (11)
Cohen, Herman N. (9)
Cohen, I. Elvin (7)
Cohen, Julian (16)
Cohen, Louis (16)
Cohen, M. Marvin (16)
Cohen, Maurice (7)
Cohen, Maurice B. (5)
Cohen, Max (7)
Cohen, Meyer J. (7)
Cohen, Oscar H. (14)
Cohen, Paul (4)
Cohen, Samuel (9)
Cohen, Samuel A. (9)
Cohen, Sidney A. (7)
Cohen, Sidney L. (7)
Cohen, Sidney P. (7)
Cohen, William (11)
Cohn, George M. (7)
Cohn, Hermann (7)
Cohn, Isidor (16)
Cohn, Royal M. (7)
Colavita, James J. (11)
Colby, Maxwell X. (13)
Cole, L. Frank (16)
Cole, Nathaniel B. (12)
Cole, Walter H., Jr. (20)
Coleman, Austin H. (10)
Coleman, Joseph G. (19)
Coleman, Russell M. (7)
Collier, Martin H. (4)
Collins, Laurence M. (14)
Collins, Louis K. (8)
Colmer, M. Jonas (7)
Colsh, LeRoy L. (7)
Colton, Ethan T., Jr. (7)
Comando, Harry N. (7)
Comeau, George W. (14)
Comfort, John B. (11)
Commini, Frank F. (11)
Comora, Herman C. (9)
Comunale, Anthony R. (20)
Conlen, Richard (4)
Conlon, Philip J. (7)
Connamacher, Harold S. (7)
Connell, Emmet J. (9)
Connolly, John J. (7)
Connolly, Joseph P. (16)
Connolly, Richard N. (7)
Connor, Clarence A. (2)
Conserva, Peter V. (16)
Conty, Anthony J. (9)
Conway, James V. (20)
Cook, Dora G. (14)
Cook, Hugh F. (7)
Cooley, Justus H., II (18)
Cooper, David P. (7)
Cooper, Irving J. (12)
Cooper, Jules (5)
Cooper, Robert A. (4)
Cooperman, Eli L. (12)
Cooperman, William (7)
Copleman, Benjamin (12)
Copleman, Hyman B. (12)
Coplin, George J. (20)
Coppoletta, Joseph M. (2)
Corbusier, Harold D. (20)
Cordasco, Peter (7)
Corio, George A. (11)
Corless, Joseph F. (9)
Corn, David (2)
Cornish, Charles H. (7)
Corrigan, Patrick H. (11)
Corson, Filbert R. (1)
Corson, Kenneth E. (6)
Cortese, Alvin E. (16)
Cosgrove, Robert A. (9)
Cosgrove, Samuel A. (9)
Costa, Philip L. (13)
Costello, William F. (14)
Cotton, Henry A., Jr. (11)
Cotton, Norman T. (16)
Cottone, R. John (11)
Cottrell, Judson G. (12)
Coughlan, Ella A. (7)
Coughlin, Frank J. (7)
Coughlin, John P. (9)
Coughlin, Joseph J. (2)
Coultas, Aldo B. (14)
Covino, Louis L. (7)
Cowan, Joseph H. (9)
Cowlbeck, H. Donald (11)
Cox, Harold C. (11)
Cox, J. Robert (17)
Cox, John C. (7)
Cox, William T. R. (20)
Cox, William W. (7)
Coxson, Harold P. (4)
Crabtree, Loren H. (20)
Cracco, Frederick A. (9)

Craig, Henry A. (18)
Crandall, John K. (2)
Crandell, C. Archie (14)
Crane, Bernard (1)
Crane, Charles G. (7)
Crane, Norman T. (20)
Crane, Percy R. (14)
Crane, Reynold M. (4)
Crapanzano, Domenico (7)
Crawford, Georgina U. (7)
Crawford, John W. (18)
Crecca, Anthony D. (7)
Crecca, William D. (7)
Cregar, John S. (7)
Cremens, John F. (16)
Crescente, Fred J. (16)
Cricco, Carl F. (9)
Crist, Walter A. (4)
Cronin, Francis J. (20)
Cronk, Edwin I. (12)
Crooks, William J. III (10)
Cropsey, Charles D. (2)
Crossfield, Henry C. (7)
Crounse, David R. (16)
Crowe, Aldrich C. (5)
Crowley, Joseph W. (4)
Cryder, Millard C. (5)
Crystell, Edward H. (7)
Ctibor, Vladimir F. (10)
Cucinella, Anthony B. (7)
Culver, S. Herbert (9)
Cummins, Ella F. (14)
Cunningham, Charles, Jr. (6)
Cunningham, Joel B. (4)
Cupaiuoli, Richard A. (9)
Curry, Marcus A. (14)
Curtis, A. Maurice (16)
Curtis, Arthur W. (7)
Curtis, Donald A. (2)
Curtis, Elbert A. (7)
Curtis, Howard C. (3)
Cziraky, Anton (9)

ASSOCIATE MEMBERS

Calabrese, Dino (2)
Cannata, Benjamin (12)
Carusi, Leonardo G. (16)
Cassio, William L. (7)
Chudzik, Edward W. (16)
Church, Charles F. (12)
Cichon, Elmer J. (16)
Cincotti, Victor (7)
Cooper, Jehu P. (7)
Cutler, Milton (1)

D

ACTIVE MEMBERS

D'Acierno, Pellegrino A. (9)
D'Addario, Anthony R. (7)
D'Agostin, Henry (2)
D'Agostini, Alfred J. (7)
D'Agostini, Robert J. (7)
Dalberg, Walter (20)
D'Alessandro, Arthur J. (7)
Dalton, S. Eugene (1)
Daly, John F. (2)
D'Amato, Charles R. (2)
D'Ambola, Philip R. (7)
D'Amico, Thomas V. (7)
Dandois, George F. (5)
Dane, Charles (7)
Dane, John (7)
D'Angelo, Joseph C. (7)
Danielson, John J. (9)
Dann, Frederick J. (7)
Dante, Pasquale (7)
Danzis, Louis (7)
Danzis, Maximillian (7)
Darby, C. Eugene (5)
Darby, I. Kermit (7)
D'Arcy, Walter E. (11)
Darden, Walter T. (7)
Darlington, Emlen P. (3)
Daron, Simeon (7)
Davenport, Irwin P. (11)
Daversa, Benjamin (13)
David, Leopold S. (4)
Davidson, E. Norwell (20)
Davidson, Harold S. (1)
Davidson, Henry A. (7)
Davidson, Maurice M. (7)
Davies, George A. (6)
Davies, George W. (7)
Davis, A. Hobson (16)
Davis, Albert B. (4)
Davis, Clarence E. (8)
Davis, Daniel (9)
Davis, E. Vernon (3)
Davis, F. Cleveland (20)
Davis, Harold L. (11)
Davis, Jacob M. (3)
Davis, John E., Jr. (11)
Davis, Louis (7)
Davis, Stanton H. (20)
Davis, Thomas C. (7)
Davison, C. Spencer (17)
Davison, Royden W. (11)
Davison, Wilbur S. (17)
Dawson, Harry (16)
Day, Samuel T. (6)
Day, Willis B. (20)
Dean, Guy K., Jr. (11)
Dear, Abraham L. (7)
DeBell, Peter J. (16)
DeBiaso, Cornelius V. (2)
DeCecio, Thomas (2)
DeCesare, Ferdinand J. (20)
Decker, Charles T. (20)
Decker, Frederick H. (10)
Decker, Henry B. (4)
DeFelice, Mario T. (14)
DeFronzo, Morando (7)
DeFuccio, Charles P. (9)
DeFusco, G. Thomas (9)
Degenhardt, Ira H. (12)
DeGerome, James H. (7)
DeGrace, Francis H. (16)
DeGregorio, Peter J. (14)
DeHart, George K. (7)
deHellebranth, Roland T. (1)
Deibert, Irvin E. (4)
Deich, Samuel R. (16)
Deichman, Charles H. (14)
Deignan, William L. (7)
Deitmaring, Francis A. (9)
Deitz, Joseph R. (11)
Delaney, Oscar M. (7)
Delario, Anthony J. (16)
Del Baglivo, Mario (9)
Delcau, Jules (13)
Del Deo, Nicholas V. (7)
Del Duca, Vincent P. (4)
DeLeonardis, James V. (7)
Del Guercio, Olindo (7)
DeLia, Emilio (7)
Della Raglone, Mario (7)
Del Mauro, Alphonse (16)
Del Negro, Albert E. (7)
DeMarco, Silverino V. (9)
Demaree, Richard H. (13)
Demarest, Gerald B. (20)
Demarest, J. Willis (2)
DeMattia, Michael (16)
Dembinski, T. Henry (11)
DeMichele, Roland V. (7)
Dempsey, J. Harvey (4)
Denbo, Elic A. (4)
Denelsbeck, J. Otis (11)
Denes, Oscar (7)
Dengler, Henry P. (20)
Denison, Ward C. (16)
DePalma, Anthony F. (7)
DePhillips, Benedict R. (7)
DeRosa, Armand (16)
DeSantis, Orazio J. (6)
DeSanto, Anthony M. (2)
Desmet, Victor F. (16)
Dessauer, Joseph (7)
Detrano, Salvatore J. (9)
DeTroia, Frederick C. (7)
Deuell, William D. (2)
Deutel, Oscar R. (7)
Deutsch, Nathan S. (20)
DeVincentis, Henry (7)
DeVincenzo, F. Richard (9)
DeVita, Anthony J. (13)
Devlin, Arthur D. (7)
Devlin, Hugh J. (7)
Dexter, Harriet E. T. (9)
DeYoe, Leon E. (16)
Dezer, Charles N., Jr. (2)
Diamond, David I. (13)
Diamond, J. George (20)
Dias, Joseph L. (7)
Dickson, John D. (2)
Dickson, T. Bruce (3)
Dieffenbach, Richard H. (7)
Dieker, Howard E. (12)
Diener, Samuel (7)
DiFino, Felix J. (7)
DiGiacomo, Harry E. (7)
DiGiacomo, William H. (7)

DiIelsi, Anthony J. (4)
Dilger, Frederick G. (2)
Dimun, John T. (11)
Dinge, Ferdinand C. (7)
Dingman, Norman M. (16)
DiNicolantonio, Vincent J. (1)
DiNorcia, Joseph (7)
Dirdack, Morris (14)
Diskan, Samuel M. (1)
Diverty, Henry B. (8)
Dochtermann, Warren P. (14)
Dodd, William E. (15)
Dodge, James T. (11)
Doggett, E. Hugh (20)
Doherty, William (20)
Doktor, David (16)
Dolsky, Irving (20)
Donahue, William J. (7)
Donchi, Sol M. (7)
Donges, Clarence B. (4)
Donnelly, John H. (7)
Donnelly, Joseph E. (16)
Donnelly, William A. (1)
Donohoe, Lucius F. (9)
Donohue, Daniel J. (9)
Doran, Ralph J. (9)
Doran, William G. (9)
Doranz, Harold K. (11)
Dorr, Henry B. (13)
Dougherty, Daniel D. (9)
Douglass, Stephen A. (16)
Douglass, William C. (18)
Dow, Robert F. (16)
Dowds, Samuel C. (7)
Downing, Perley E. (12)
Downs, Louis S. (12)
Downs, Roscius I. (3)
Doyle, George F. (2)
Doyle, John J. (9)
Drake, Daniel E. (16)
Drake, Leo B. (19)
Drake, Paul F. (21)
Dranow, Paul (7)
Drapkin, Berta (7)
Dredge, Thomas J. (14)
Dresel, Irmgard (18)
Dreskin, Jacob L. (7)
Drewniany, Bernardine (7)
Drezner, Henry L. (11)
Driscoll, Charles D. (4)
Driscoll, Raymond S. (9)
Drossner, Jacob L. (4)
DuBois, Morris G. (7)
duBusc, L. C. Victor (20)
Duffy, Edward P., Jr. (7)
Duffy, Joseph F. (2)
Duisberg, Richard E. H. (2)
Dukes, Howard R. (9)
Dulany, Theodore L. (7)
Dulin, Everett V. (7)
Duncan, Owsley B. (16)
Dunham, Malcolm M. (12)
Dunn, H. Irving (20)
Dunn, John S. (17)
Dunn, Theodore B. (7)
Dunning, Walter L. (16)
Dupuy, Jean G. (20)
Durchlag, E. Nelson (7)
Durham, Robert B. (1)
Durham, Royal E. (1)
Durrah, Fred F. (20)
Duschock, Edward F. (12)
Duvall, Albert I. (13)
Dwork, Harold K. (7)
Dwoyer, Leon C. (20)
Dwyer, Henry E. (16)
Dwyer, William A. (16)
Dyer, Edward H. (1)
Dzienis, John (11)

ASSOCIATE MEMBERS

Davis, Harold (2)
Dein, Harry (1)
D'Elia, William J. (13)
DeLuca, Louis (2)
Dengrove, Edward (13)
Drewery, Robert E. (7)
Dul, Emil J. (2)

E

ACTIVE MEMBERS

Eagleton, Wells P. (7)
Eames, William N. (11)
Earp, Ruth (14)
Eason, Samuel W. (20)
East, Isaac C. (12)
Ebenfeld, Samuel W. (7)
Ebner, Paul G. (4)
Echikson, Joseph I. (7)
Eck, Daniel B. (7)
Eckert, Walter L. (1)
Eckhardt, Ralph A. (14)
Eddy, Lester R. (19)
Edelberg, Sidney S. (18)
Edelen, James J. (7)
Edelson, Samuel (13)
Edgar, Malcolm S. (20)
Edgerly, Sherburn E. (2)
Edlkraut, Edward C. (16)
Edwards, J. Bennett (2)
Edwards, Lena F. (9)
Ehrenfeld, Edward (16)
Ehrenfeld, Irving (16)
Ehrlich, Edward (7)
Ehrlich, Max (20)
Ehrlich, William E. (7)
Ehrlich-Morrow, Laura E. (2)
Eichler, Bernard B. (7)
Ein, William B. (7)
Einhorn, Samuel E. (7)
Eisemann, Jerome S. (16)
Eisenberg, David S. (7)
Eisenhower, J. S. D. (5)
Eisenstodt, Lester W. (7)
Ekings, Frank P. (16)
Elias, Elmer J. (11)
Ellenson, Solomon S. (13)
Elliott, Frazier J. (1)
Ellis, Alexander (4)
Ellis, Arthur J. (7)
Ellmers, Basil J. (2)
Elsasser, Theodore H. (9)
Elwood, Benjamin J. (9)
Ely, Lancelot (18)
Emerson, Linn (7)
Emmer, S. Wolfe (7)
Emory, George B., Jr. (14)
Engelhart, Ferdinand K. (11)
Englander, Charles (7)
English, Harrison F., III (11)
English, John T. (7)
English, Samuel B. (10)
Enright, James G. (9)
Epstein, Harry B. (7)
Epstein, William M. (7)
Erber, Leonard B. (1)
Erdman, George L. (7)
Erler, Robert E. (7)
Ernest, Richard B. (11)
Ernst, Philip A. (1)
Ervin, Millard B. (7)
Esposito, Amedeo C. (14)
Esposito, Anthony L. (16)
Esposito, Antonio L. (1)
Essertier, Edward P. (2)
Essertier, Harland C. (2)
Esty, Geoffrey W. (20)
Etheridge, Charles H. (7)
Ettinger, Samuel (9)
Eulner, Elmer H. (12)
Evans, Charles H. (7)
Evans, David P. (7)
Evans, Edgar E. (17)
Evans, Edgar J. (14)
Evans, J. Lawrence (9)
Evans, J. Lawrence, Jr. (2)
Evans, Joseph O. (20)
Ewens, Arthur E. (1)
Ewing, Harvey M. (7)
Ewing, Leslie H. (4)
Eynon, Harold K. (4)
Eynon, James R. (4)

ASSOCIATE MEMBERS

Edelson, Edmond (7)
Edwards, Walter R. (11)

F

ACTIVE MEMBERS

Faber, Edward (9)
Fabian, Paul L. (11)
Fabriele, John B. (9)
Facciolo, Frank (9)
Fader, Ferdinand (7)
Fagan, James L. (12)
Fager, Rudolph O. (7)
Fahrenbruch, Frederick D. (3)
Failing, Brayton E. (7)
Failmezger, Theodore R. (14)
Faison, John B. (9)
Falcone, Nicholas A. (18)
Falconer-Slater, Katherine (20)
Falkinburg, LeRoy W. (15)
Falvello, Nicholas A. (14)
Fanburg, Sol J. (7)
Fanelli, Antonio (12)
Farkas, Gustav (16)
Farkas, Morris (7)
Farmer, Vincent (2)
Farmer, Walter D. (11)
Farr, Irving L. (7)
Farr, Walter J. (2)
Farrell, Edgar A. H. (4)
Fasano, Giovanni (7)
Fath, Marcus A. (5)
Fattel, Henry C. (9)
Faughnan, Rose C. (7)
Faulkingham, Ralph J. (12)
Faux, Frederick J. (8)
Fava, Philip V. (7)
Fazio, Vincent J. (13)
Featherston, Daniel F. (13)
Fechner, Fred J. (2)
Fechner, Herta (2)
Fechner, Julius (7)
Federer, John J. (9)
Feher, Ladislas A. M. (12)
Feigenoff, Israel (16)
Fein, Bernard (7)
Feinberg, Harry (9)
Feinberg, Harry D. (13)
Feinsod, Samuel N. (7)
Feinstein, Louis (1)
Feldman, Frank H. (7)
Feldman, Joel (13)
Feleppa, Edward E. (20)
Feliciano, Vincent (16)
Feller, William (9)
Feman, J. George (13)
Fendrick, Edward (7)
Fenimore, Edward D. (9)
Fenster, Morton N. (16)
Fenton, Tennant E. (13)
Fenwick, John R. (16)
Fermaglich, Harry B. (2)
Fern, Samuel S. (7)
Ferrari, Andrew F. (2)
Ferrary, Paul B. (16)
Ferriss, Ruth B. (14)
Fessler, A. James (11)
Fessman, John W. (4)
Feuer, Joseph A. (7)
Flalk, Harry (9)
Fi ke, Sylvia A. (9)
Fiedler, Michael J. (20)
Field, Frank L. (18)
Fielding, William M. (16)
Fiering, Abraham M. (16)
Fietti, Vincent G. (2)
Fifer, William T. (9)
Figliolino, Francis (20)
Figurelli, Francis A. (9)
Filippone, Ames L. (7)
Filkins, Cedric E. (4)
Fine, Hyman P. (12)
Fine, Irvin J. (12)
Fine, Sydney G. (11)
Finegan, Paul J. (11)
Finger, Frederick A. (9)
Fink, A. Elston (7)
Fink, Irving E. (7)
Fink, Stanley J. (20)
Finke, Charles H. (9)
Finke, George W. (2)
Finke, John H. D. (2)
Finkel, Joshua (7)
Finkelstein, Abe S. (7)
Finkle, Lester J. (11)
Finkler, Rita S. (7)
Finn, Henry R. W. (9)
Finnerty, Urban R. (7)
Fiorello, Joseph R. (11)
Fischbach, Adolph D. (3)
Fischbein, Martin M. (7)
Fischer, David D. (7)
Fischer, Edward J. (7)
Fischer, Louise (7)
Fischman, Harold H. (7)
Fish, Clyde M. (1)
Fishbein, Elliot (16)
Fisher, Samuel (16)
Fisher, Stella C. (4)
Fishkoff, Alexander H. (12)
Fisler, Charles F. (8)
Fitch, Thomas S. P., (20)
Fithian, George W. (12)
Fitzhugh, William F. (2)
Fitzpatrick, Leo J. (2)
Flanagan, James F. (7)
Flanagan, John J. (7)
Flax, Charles H. (7)
Flax, Ira I. (7)
Flax, Jacob L. (7)
Fleischmann, Viola G. (7)
Fleming, Charles L. (17)
Fleming, Joseph A. (7)
Flicker, David J. (9)
Fliegel, William M. (2)
Flint, Edgar T. (18)
Flitcroft, William (16)
Floody, Robert J. (7)
Flower, Morrie A. (7)
Fluck, David A. (11)
Fluck, Paul H. (10)
Flynn, Edward A. (7)
Foley, James F. (7)
Fooder, Horace M. (8)
Forbes, John S., Jr. (14)
Ford, Theodore R. (7)
Forer, Robert (11)
Forney, Norman N. (12)
Forney, Norman N., Jr. (12)
Forrest, Henry (12)
Forsyth, Kenneth C. (7)
Fort, J. Irving (7)
Fort, William B. (20)
Fortay, Steven O. (16)
Forte, Daniel L. (7)
Forte, F. Chester (2)
Forte, Frank S. (7)
Fortuin, Floyd (16)
Fortunato, Samuel J. (7)
Fost, William H. (7)
Foster, Frank L. (20)
Foster, Herbert W. (7)
Fowler, Richard M., Jr. (1)
Fowler, Royale H. (7)
Fox, William W. (1)
Frame, Dorothy L. (7)
Francy, Donald G. (7)
Frank, Herman I. (9)
Frank, Morris (9)
Frank, Myrtile (1)
Frank, Nathan (9)
Frank, Perry (1)
Frank, Simon C. (7)
Franklin, Frank A. (7)
Franklin, I. Harold (9)
Franklin, Joseph E. (20)
Franklin, Lewis J. (20)
Frantz, Max K. (4)
Franzoni, Andrew E. (11)
Fratantuno, Michael J. (7)
Fraulo, Louis (16)
Frazee, William H., Jr. (15)
Freedman, Harold H. (13)
Freedman, Jacob S. (16)
Freeland, Frank (2)
Freeman, George C. (7)
Freeman, Ray M. (20)
Freeman, Richard D. (7)
Freinkel, Jacob (7)
French, Harry J. (4)
Freyberger, George A. (9)
Freymann, Walter (9)
Fridrich, Harry E. (4)
Friedburg, George H. (20)
Friedenberg, Sidney (4)
Friedenthal, Bernard (12)
Friedland, Arnold J. (6)
Friedlander, Kurt F. (7)
Friedman, Abraham I. (2)
Friedman, Edna C. (16)
Friedman, Harry (7)
Friedman, Hyman (7)
Friedman, Max (11)
Friedman, Meyer H. (11)
Friedman, Milton (7)
Friedmann, Leonard L. (11)
Friedrich, Adam H. (7)
Fritsch, Alfred (7)
Fritts, Lewis C. (18)
Fritz, John F., Jr. (10)
Froelich, Joseph C. (7)
Frohwein, Ida H. (20)
Fromkin, Charles (6)
Frost, Inglis F. (14)
Fruchtbaum, Robert P. (7)
Fuchs, Jacob N. (11)
Fuhrmann, Barclay S. (10)
Furman, Benjamin A. (7)
Furman, Sol T. (9)
Furst, Nathan J. (7)

ASSOCIATE MEMBERS

Finnegan, William R. (12)
Firtel, Saul I. (7)
Folmer, Edward (11)
Franklin, Charles M. (11)
Freeman, William S. (12)
Friedmann, Gustav (16)

G

ACTIVE MEMBERS

Gadek, Stanley A. (12)
Gadek, William V. (12)
Gadomski, Casimir F. (20)
Galgozy, Julius (18)
Galioto, Frank M. (7)
Gallardo, Agustin (16)
Gallaway, George E. (20)
Gallo, James S. (16)
Gamba, Joseph (7)
Gambacorta, Leopoldo (7)
Gambill, Perry J. (14)
Gamon, Robert S. (4)
Ganley, Arthur J. (7)
Gannon, Joseph M. (20)
Ganot, Frank I. (7)
Gantt, Margaret H. (14)
Garbarini, John G. (9)
Gardam, Joseph W. (7)
Gardner, Kenneth E. (7)
Garfinkel, Abraham (10)
Garibaldi, Louis J. (9)
Garnett, Robert (16)
Garrison, W. Sherman (6)
Garwood, Norman W. (11)
Gatti, Joseph D. (2)
Gauzza, Valentine P. (12)
Gaylor, Earl L., Jr. (7)
Geannette, Ernest D. (7)
Geary, Daniel J. (14)
Geary, Paul (20)
Geary, Russell D. (3)
Gebirtig, Theodore (14)
Gehl, Sidney H. (7)
Geiger, Harold C. (16)
Geissler, Elmer E. (4)
Gelb, Jerome (7)
Gelber, Isaac (20)
Geller, Samuel (7)
Gellman, William B. (16)
Gelman, Sidney (16)
Gencher, Benjamin (7)
Gennell, Ernest (7)
Gentile, Ernest R. (18)
George, Melbourne E. W. (7)
Gerard, Arpad G. (12)
Gerard, Patrick D. (7)
Gerendasy, Julius (20)
Gerhardt, Paul E. (7)
Germain, Raymond J. (10)
German, George B. (4)
Gerne, Timothy A. (9)
Gerner, Harry E. (9)
Gershenfeld, David B. (7)
Gershenson, Wilbur M. (16)
Gershman, Joseph G. (2)
Gessner, Gerard R. (12)
Gesswein, Carl A. (13)
Ghee, Euclid P. (9)
Giambra, Sante M. (16)
Giardina, John S. (7)
Giardina, Vincent J. (7)
Gibb, Alice S. (20)
Gibbins, A. Leslie (7)
Gibson, Charles F. (3)
Giffoniello, Arthur A. (7)
Gifford, William R. (7)
Giglio, Alphonsus S. V. (20)
Gilady, Raphael (2)
Gilbert, Harold F. (7)
Gilbert, Philip D. (4)
Gilbert, Samuel M. (7)
Gilbertson, Robert L. (14)
Gilligan, Walter W. (7)
Gillis, Alfred G. (8)
Gilman, Charles M. B. (7)
Gilmour, John R. (7)
Gilpin, Fletcher (20)
Gindhart, John H. (11)
Ginsberg, George (9)
Ginsburg, Samuel (16)
Giordano, Salvatore (14)
Giordano, William C. (2)
Girardo, Anthony J. (4)
Gittelman, Morton (20)
Gitterman, David A. (2)
Giuffra, Frank (7)
Giuliana, Robert A. (7)
Gladstone, Albert L. (2)
Glaser, Emanuel (20)
Glasgow, Thomas M. (16)
Glass, Benjamin E. (20)
Glass, Harry L. (20)
Glass, Oscar (7)
Glass, William H. (7)
Glasser, Benjamin F. (12)
Glassner, Frank (20)
Glasston, Hyman M. (20)
Glazebrook, Francis H. (14)
Glazer, Edward (13)
Glazier, Jesse T. (7)
Gleason, Thomas P. (9)
Gluckman, I. Edward (7)
Gluckman, Saul K. (7)
Glynn, S. Robert (7)
Gobel, Stanley J. (12)
Gochman, Harry M. (16)
Godfrey, Alan O. (7)
Goeller, Jacob D. (7)
Goff, Frank J. (13)
Goffman, Emanuel (7)
Goldberg, Benjamin M. (11)
Goldberg, David (2)
Goldberg, Harold H. (7)
Goldberg, Harry C. (12)
Goldberg, Isidore (12)
Goldberg, Jacob (13)
Goldberg, Louis E. (7)
Goldberg, Samuel A. (7)
Golden, Clement H. (7)
Golden, William M. (20)
Goldenberg, Raphael R. (16)
Goldfarb, Abraham (2)
Goldfield, Harold H. (20)
Golding, Harry N. (16)
Goldmacher, Herman B. (20)
Goldman, David L. (9)
Goldman, Jerome (7)
Goldman, Leo L. (11)
Goldman, Lester M. (7)
Goldman, Samuel (4)
Goldman, Solomon (12)
Goldmann, Joseph (7)
Goldsmith, Alfred S. (9)
Goldstein, Abraham (15)
Goldstein, Edward W. (16)
Goldstein, Henry Z. (7)
Goldstein, Herman H. (20)
Goldstein, Hyman I. (4)
Goldstein, Joseph D. (9)
Goldstein, Samuel (1)
Goldstein, Samuel M. (7)
Goldstein, William H. (7)
Goldstone, Karl H. (9)
Gonczy, Edward J. (20)
Good, Richard (9)
Goodman, Kenneth (7)
Goodrich, Stewart L. (9)
Gordon, A. Julius (7)
Gordon, Benjamin L. (1)
Gordon, Charles D. (14)
Gordon, Frank S. (21)
Gordon, Isaac L. (9)
Gordon, J. Berkeley (13)
Gordon, Maurice B. (1)
Gordon, Milton H. (4)
Gordon, Samuel (16)
Gorenberg, Harold (9)
Gormley, Cyrus M. (16)
Gorog, Nicholas M. (12)
Gorson, Samuel F. (1)
Gorten, Manfred L. (7)
Gosper, Ralph W. (4)
Gottlieb, Morris (1)
Gould, John H. (16)
Gould, Werner (2)
Graddick, Lester W. (14)
Graeter, F. Albert (16)
Graham, Archibald F. (16)
Graham, Ernest E. (11)
Graham, Richard B. (15)
Graham, Theodore K. (16)
Granelli, Humbert A. (9)
Grant, Francis (7)
Grant, Raymond J. (14)
Grant, William E. (20)
Grant, William F. (7)
Grasso, Anthony P. (7)
Graves, Charles C., Jr. (13)
Gray, Charles M. (6)
Gray, John W. (7)
Gray, W. Burritt (18)
Green, David W. (17)
Green, Thomas J. (15)
Greenberg, George A. (18)
Greenberg, Jacob L. (7)
Greenberg, Max (20)
Greenberg, Philip (9)
Greenberg, Samuel (7)
Greenberg, Solomon (9)
Greene, Albert D. (9)
Greene, Edwin C. (6)
Greene, Harry (9)
Greenfield, Arthur W. (2)
Greenfield, Bernard H. (7)
Greenfield, Herbert (7)
Greenfield, Leonard S. (7)
Greenfield, William J. (2)
Greengrass, Jacob J. (16)
Greenwald, Theodore L. (7)
Greenwell, Albert W. (16)
Greenwood, Samuel B. (7)
Greenwood, William R. (12)
Greer, Melvin A. (7)
Gregorius, Ralph F. (7)
Gregory, Marie F. (14)
Gregory, Mildred G. (7)
Greifinger, Marcus H. (7)
Greifinger, William (7)
Grenhart, George W. (4)
Gribbin, James A. (11)

Gricco, Anthony L. (6)
Grieco, Emil H. (9)
Grier, Robert M. (1)
Griesemer, Z. Lawrence (20)
Griffey, William C. (4)
Griffin, Guy B. (7)
Griffith, Roy (7)
Grimes, Robert R. (2)
Griscom, I. Norwood (14)
Griscom, Lee E. (4)
Griswold, Merton L., Jr. (20)
Groff, Parker A. (2)
Gross, Irving (7)
Gross, Max (1)
Grossblatt, Philip (7)
Grossman, Morris (9)
Grossman, Rubin (9)
Gruber, William L. (7)
Grubin, Harold (7)
Grubowski, Joseph N. (9)
Grueninger, Edward F. (2)
Gruhler, Jean A. (1)
Grundorfer, Joseph (7)
Grunt, Louis (7)
Guarraia, Joseph (16)
Guertin, Diomede (18)
Guglielmelli, Angelo D. (11)
Guidi, Guido M. (20)
Guidice, Vincent W. (2)
Guidotti, Frank P. (11)
Guion, Edward (1)
Gulick, James B. (7)
Gullord, Edward G. (7)
Gurley, Katharine A. (9)
Gurnee, Quinby D. (16)
Gurshman, Sol. (12)
Gutmann, Erwin K. (9)
Gutowski, Joseph M. (12)
Gutowski, Walter T. (7)

ASSOCIATE MEMBERS

Gahan, Emanuel (11)
Gartlan, Bernard W. (15)
Gindhart, Floyd D. (11)
Goldberg, Bernard R. (7)
Goldman, Sol B. (16)
Golish, Harry L. (16)
Gordon, William (16)
Goyne, James B. (11)
Graber, Irving (13)
Granger, James R. (11)
Grossbard, Paul (16)
Grossman, Walter (12)

H

ACTIVE MEMBERS

Hadley, C. Frazer (4)
Hadley, C. Frazer, Jr. (4)
Hadley, Elinor E. (7)
Hafetz, M. Morris (11)
Hagen, Walter H. (7)
Haggerty, D. Leo (11)
Hagman, Frank E. (7)
Hagovsky, Albert J. (2)
Hahn, Katherine B. (7)
Hahn, William H. (7)
Haight, Harry W. (12)
Haines, Edgar J. (3)
Haines, Emerson S. (13)
Haines, F. B. Lane (5)
Haines, Mabel C. S. (4)
Haines, Willits P. (5)
Halbeisen, William A. (4)
Halbstein, Bernard M. (13)
Haldeman, Robert E. (3)
Hale, Matthew J. (3)
Haley, Paul W. (7)
Hall, Perry O. (9)
Hall, Wayne W. (16)
Hall, Winthrop H. (20)
Haller, Olga (7)
Hallett, Frederick S. (2)
Halligan, Earl J. (9)
Halligan, Harold J. (9)
Hallinger, Earl S. (4)
Hallock, Wilton J. (20)
Halnan, John J., Jr. (16)
Halperin, David (9)
Halpern, Herman (2)
Halpern, Jesse O. (2)
Halpern, Melvin M. (7)
Halpern, Samuel (1)
Halpern, William (7)
Halprin, Harry (7)
Halsey, Levi W. (7)
Hambright, Arthur M. (16)
Hamilton, Lloyd A. (10)
Hamilton, Robert G. (7)
Hamley, John J. (20)
Hammell, Frank M. (11)
Hampton, George R. (14)
Hanan, James T. (7)
Hancock, Michael Q. (13)
Hand, Frederick G. (7)
Handler, Harry (9)
Haney, John J. (11)
Hansen, Harold T. (7)
Hansen, Harry (20)
Hanson, Alfred S. (4)
Hanson, Carl G. (20)
Hantman, Harold (7)
Harbeson, James P., III (4)
Harden, Albert S. (7)
Harden, Albert S., Jr. (7)
Hardy, John W. (13)
Harley, Halvor L. (1)
Harman, Byron M. (7)
Harman, J. Reginald (11)
Harman, William J. (11)
Harreys, Charles W. (16)
Harrington, J. Henry (14)
Harris, Morris (7)
Harris, William O. (1)
Harryman, William K. (2)
Harter, Louis F. (9)
Hartman, Luther M. (3)
Hartman, Winfield L., Jr. (7)
Hartwell, H. Ameroy (9)
Harvey, John W. (9)
Harvey, Robert K. (7)
Harvey, Thomas W., Jr. (7)
Harz, William V. (9)
Haschec, Walter (7)
Haskin, Aaron H. (7)
Hasking, Arthur P. (9)
Hasney, Frederick A. (7)
Hatch, Harold S. (14)
Hatcher, George A. (7)
Hatem, Elias J. (16)
Hauber, Eugene A. (12)
Hauck, Lydia R. B. (7)
Hauck, William H. (7)
Hauptman, Harry (9)
Haury, Victor G. (4)
Hausman, Samuel W. (13)
Haven, Samuel C. (14)
Hawes, Vernon L. (2)
Hawke, Edward K. (19)
Hawkes, E. Zeh (7)
Hawkes, Stuart Z. (7)
Hayden, Walter G. (15)
Hayes, Gerald W. (7)
Hayman, Irving R. (16)
Hays, Roy G. (4)
Haywood, Henry (12)
Heatley, William (13)
Heaton, Stuart C. (18)
Hebble, Howard M. (3)
Hegeman, Runkle F. (18)
Heilbrunn, Julius (9)
Heineken, Theodore S. (7)
Hekimian, Jacob H. (9)
Helff, Joseph R. (2)
Heller, Abraham R. (7)
Heller, George (2)
Heller, Nathan B. (7)
Heminway, Norman L. (18)
Hemphill, Everett H. (4)
Hendlich, Milton G. (7)
Henle, Carye-Belle (7)
Hennig, Paul F. (7)
Henriksen, J. Bruce (15)
Henry, Frank C., Jr. (12)
Henry, George (10)
Henry, Norman (6)
Hensle, Otto S. (2)
Herbener, Eugene G. (15)
Hermann, John H. (7)
Hernandez, Manuel (9)
Herndon, Lewis S. (7)
Herold, Harvey T. (7)
Herradora, Juan R. (9)
Herrington, Lee R. (20)
Herrman, William G. (13)
Hersh, David H. (7)
Hersohn, William W. (1)
Hess, George A. (11)
Hess, L. Elmore (1)
Hesseltine, Clair E. (12)
Hessert, Edmund C. (4)
Hewson, George F. (7)
Heyman, Arthur (7)
Heymann, Ernest F. (13)
Hicks, Alfred M. (7)

Hiden, Joseph C. (11)
Higgins, Gerald L. (9)
Higgins, John T. (9)
Higi, Joseph E. (7)
Hiler, Stuart A. (14)
Hilker, George F. (12)
Hill, Clarence T. (20)
Hill, Dean F. (19)
Hill, James O. (7)
Hill, Robert H. (7)
Hillel, Joseph (9)
Hilliard, William T. (17)
Hillmann, Frederick C. (16)
Hillsman, R. Bryan (2)
Hilton, Clarence O. (7)
Hinckley, Livingston S. (7)
Hindle, F. Lawton (13)
Hinton, Samuel H. (12)
Hipple, Percy L. (20)
Hird, Emerson F. (18)
Hirsch, Allen H. (6)
Hirsch, Arthur (5)
Hirsch, John J. (2)
Hirsch, Solomon (9)
Hirsch, Theodore (7)
Hirschfield, Bernard A. (11)
Hitzemann, Louis A. (2)
Hnat, Frederick (20)
Hobart, Richard T. (7)
Hochheimer, Arthur (18)
Hodas, Sidney M. (13)
Hofbauer, Ernest (11)
Hofer, Clarence J. M. (12)
Hofer, William R. (4)
Hoffman, Charles A. (20)
Hoffman, Charles W. (12)
Hoffman, Florentine M. (12)
Hoffman, Harry S. (1)
Hogan, James J. (15)
Hogan, Marshall D. (14)
Holderith, Albert E. (7)
Holland, Moses H. (9)
Holland, Reuben J. (20)
Holler, Henry G. (7)
Hollingsworth, H. Hale (16)
Hollinshed, Beulah S. (4)
Hollinshed, Ralph K. (8)
Hollywood, James L. (9)
Holman, Francis W. (13)
Holmes, George J. (7)
Holmes, Grace A. (20)
Holmes, H. David (1)
Holmes, Thomas J. E. (16)
Holoman, M. Browne (1)
Holster, Stephen G. (16)
Holt, Edward Z. (1)
Holt, Evelyn (20)
Holt, Herman H. (16)
Holters, Otto R. (13)
Holtz, Harry M. (7)
Holtzman, Michael (20)
Hoops, Harold J. (2)
Hooton, Thomas C. (7)
Hopping, Richard A. (7)
Horhovitz, George I. (11)
Horland, Aaron H. (7)
Horn, Harry (7)
Horn, Max (7)
Hornberger, J. Howard (3)
Hornstine, Harry H. (5)
Horoschak, Anne (20)
Horowitz, Herman J. (2)
Horre, George W. H. (20)
Hosp, Paul H. (7)
Howard, J. Edgar (4)
Howard, James W. (7)
Howell, E. Gaylor (12)
Howell, Thomas W. (7)
Howeth, John L. (9)
Howley, Barth, Jr. (12)
Hubach, Maximilian F., Jr. (7)
Hubbard, Robert Y. (7)
Huber, William H. (7)
Huberman, John (7)
Hubert, Antonio O. (14)
Hudson, Howard S. (1)
Hughes, Arthur J. (4)
Hughes, Frank J. (4)
Hughes, Frank R. (5)
Hughes, Frederic J. (20)
Hughes, Harold F. (5)
Hughes, J. Vernon (16)
Hughes, Joseph F. (8)
Hughes, Lee W. (7)
Hughes, Samuel B. (5)
Hughes, Thomas E. (4)
Hull, Donald B. (2)
Humbert, Joseph C., Jr. (21)
Hummel, Ernest G. (4)
Hummel, Lee C. (17)
Hummel, Merwin L. (4)
Humphrey, Hubert G. (20)
Humphries, Robert E. (7)
Hunt, Melvin M. (12)
Hunt, Thomas F. (20)
Hunter, Edward R. (3)
Hunter, Floyd D. (11)
Hurff, J. Wallace (7)
Husik, Franklin B. (8)
Huss, Louis (9)
Husted, Gerald W. (4)
Husted, Samuel H. (18)
Hutchinson, A. Dunbar (11)
Hutchinson, George F. (11)
Hutner, Cyril I. (12)
Hutton, Frederick T. (20)
Hyer, Godfrey S. (18)
Hyman, Charles (1)
Hymowitz, Ben (7)

ASSOCIATE MEMBER

Hamburg, Meyer M. (12)
Hillman, Ernest C., Jr. (7)

I

ACTIVE MEMBERS

Ianacone, John A. (16)
Iatesta, Matthew (7)
Ill, Edmund W. (7)
Ill, Herbert M. (7)
Imbleau, Joseph E. L. (20)
Imhoff, John G. (9)
Imhoff, Robert E. 3)
Infield, Gerald L. (1)
Inge, Hutchins F. (7)
Ingling, Harry W. (13)
Introcaso, Dominick A. (9)
Iraggi, James V. (16)
Ironside, Paul A. (4)
Irvin, John S. (1)
Irving, Henry C. (9)
Irwin, James R. (7)
Irwin, John H. (2)
Isaac, Benoit C. (7)
Ishkhanian, Nouri I. (9)
Israeloff, Howard H. (7)
Ivey, Evelyn P. (14)
Ivins, William C. (11)
Ivory, Harry S. (15)
Izenberg, David (16)

ASSOCIATE MEMBERS

Iannone, Angelo B. (7)
Idelcowitz, Marle (12)
Israel, Joseph (7)

J

ACTIVE MEMBERS

Jablonski, John J. (12)
Jack, H. Wesley (4)
Jacks, Oscar (9)
Jackson, Charles H. (4)
Jackson, Elmer C. (21)
Jackson, George H. (7)
Jackson, Kenneth K. (7)
Jacobitti, Edmund E. (2)
Jacobs, Alan L. (20)
Jacobs, William (7)
Jacobson, J. Joseph (1)
Jacobson, Murray B. (12)

Jaeckle, Charles E. (7)
Jaffe, Benjamin (9)
Jaffe, Herman M. (9)
Jaffe, Hyman (16)
Jaffin, Abraham E. (9)
Jahn, Albert G. (16)
James, Bart M. (7)
James, J. Thomas (11)
Jamison, William F. (13)
Jani, Frank F. (16)
Janifer, Clarence S. (7)
Janoff, Henry (11)
Jaques, J. Eugenia (9)
Jarmulowsky, Harry (16)
Jarvis, Dainel G. (7)
Jaslow, Seymour P. (2)
Jaso, James V. (7)
Jaspan, Samuel C. (11)
Jedel, Meyer (7)
Jehl, Joseph R. (16)
Jenkins, Alvah R. (2)
Jenkins, Arthur M. (10)
Jenkins, R. Jewett (7)
Jennings, Robert E. (7)
Jentz, John H. (9)
Jessurun, Samuel H. (7)
Joelson, Dora (16)
Joelson, Morris S. (16)
Joffe, Philip M. (16)
Joffe, Sidney H. (16)
Johnsen, Sigurd W. (16)
Johnson, Archie W. (9)
Johnson, George F. (19)
Johnson, G. Leonard (2)
Johnson, Harold F. (20)
Johnson, Herbert F. (4)
Johnson, John F. (11)
Johnson, Robert A. (7)
Johnson, V. Earl (1)
Johnston, Julian F. (14)
Johnston, Rufus O. (2)
Johnston, Sidney F. (2)
Jonas, August (17)
Jones, Clement M. (9)
Jones, Granville L. (13)
Jones, Helen E. (13)
Jones, Herbert E. (20)
Jones, J. Morgan (9)
Jones, John C. (4)
Jones, Lewis H. (20)
Jones, Rhys (7)
Jones, William F. (18)
Jonitz, Robert (7)
Jordan, Joseph C. (13)
Jordan, Walter L. (2)
Joseph, Benjamin M. (9)
Joseph, Morris (16)
Joy, Ernest H. (15)
Judge, John F. (7)
Judson, G. Vernon, Jr. (4)
Judy, Kenneth H. (9)
Jukofsky, Isidore D. (2)
Just, Francis (7)
Justin, Arthur W. (9)

ASSOCIATE MEMBER

Jacobson, Benjamin D. (12)

K

ACTIVE MEMBERS

Kachdorian, Vartan (11)
Kaderabek, Erwin J. (7)
Kahn, Leo (1)
Kahrs, Grace M. (7)
Kaighn, Charles B. (1)
Kain, Thomas M. (4)
Kainer, Herbert (9)
Kakasoik, Emil J. (2)
Kalb, S. William (7)
Kallen, Arnold M. (7)
Kalter, George E. (7)
Kandra, Paul H. (20)
Kaney, Emil M. (7)
Kaplan, Henry L. (7)
Kaplan, Herman B. (9)
Kaplan, Isaac (2)
Kaplan, S. Bernard (7)
Kaplan, Samuel D. (20)
Kapp, Carl G. (20)
Karnay, Francis (20)
Karshmer, Ernest E. (20)
Karshmer, Nathan (12)
Kassow, Philip B. (21)
Kastler, Franz (2)
Katz, Harry (16)
Katz, Jacob D. (9)
Katz, Sidney (9)
Katz, Theodore (20)
Katzin, Eugene M. (7)
Kauder, Warren G. (7)
Kauffmann, Louis J. (6)
Kaufman, Jerome G. (7)
Kaufman, Michael J. (7)
Kavanaugh, Daniel E. (7)
Kay, Albert E. (12)
Kay, Clarence R. (18)
Kazmann, Harold A. (13)
Kearney, Edward P. J. (7)
Kearney, John V. (9)
Keating, Charles A. (16)
Keating, Joseph M. (16)
Keegan, Thomas D. (9)
Keeney, Cadwell B. (20)
Keeney, James C. (9)
Keil, Sigmund S. (20)
Keim, William F., Jr. (7)
Keir, Floyd E. (2)
Keith, Theodore R. (7)
Kelemen, Nicholas M. (7)
Keller, Michael L. (16)
Kelley, Ray H. (16)
Kelly, Bernard S. (9)
Kelly, Harry R. J. (9)
Kelly, Leo J. (12)
Kemeny, George (20)
Kemeny, Imre (12)
Kempe, George (7)
Kennedy, A. Andrew (16)
Kennedy, Eugene T. (16)
Kennedy, John W. (9)
Kennedy, William M. (7)
Kenney, John A. (7)
Keppler, Charles, Jr. (16)
Kern, E. Clarence (7)
Kerns, Francis J. (7)
Kessell, John S. (7)
Kessler, Edward I. (14)
Kessler, Henry B. (7)
Kessler, Henry H. (7)
Keyser, David (4)
Kibbe, Milton H. (20)
Kidd, Ruth W. (20)
Kiely, Eugene M. (9)
Kiessling, Charles E. (7)
Kiley, John E. (7)
Kilts, Winfield S. (2)
Kim, Gay B. (16)
Kimler, William D. (4)
Kimmel, Charles (7)
Kimmel, M. Leonard (9)
Kimmel, Seymour S. (21)
Kinczel, John A. (11)
King, Alden P. (14)
King, Chester A. (2)
King, Louis I. (7)
Kingma, John G. (2)
Kingslow, George L. (2)
Kinley, John W. (7)
Kinney, Burton O. (16)
Kirkby, Cyril S. (7)
Kirkman, Leroy G. (7)
Kirkwood, Allan S. (7)
Kirschner, Martin I. (19)
Kissinger, Donald J. (2)
Klapper, Lester L. (20)
Klarich, Philip (4)
Kleiber, Estelle E. (12)
Klein, Alexander (12)
Klein, Alfred (9)
Klein, Andrew J. V. (7)
Klein, Edward C., Jr. (7)
Klein, Edward F. (12)
Klein, Julius (9)
Klein, Milton (14)
Klein, William (12)
Kleinberger, Harry H. (7)
Kleiner, Samuel (16)
Kleinman, Maurice (7)
Kleinmann, Eberhart H. (16)
Klempner, Paul (11)
Klenk, Joseph P. (7)
Kler, Joseph H. (12)
Kline, George L. (7)
Kline, Herman (1)
Kline, Joseph J. (11)
Kline, Oram R. (4)
Kloby, John J. (20)
Klompus, Irving (18)
Klosk, Emanuel (7)
Klosterman, Julius A. (2)

Klughaupt, Dorothy K. (16)
Knapp, Richard E. (2)
Knapp, Victor (13)
Knauer, Charles H., Jr. (11)
Knauer, George (20)
Knight, Augustus S. (18)
Knight, Richard vanD. (20)
Knight, William T. (2)
Knowles, Frederick E. (14)
Knowles, George M. (2)
Knowles, James S. (6)
Knox, Charles A. (2)
Knox, Harriet L. (2)
Knox, Howard A. (10)
Kobes, John J. (7)
Koeck, George P. (7)
Koelsch, Frederick J. (12)
Koenig, Bertram (16)
Koerber, George (16)
Kohn, Joseph J. (11)
Kohn, Leo (7)
Kohn, Ralph B. (11)
Kohut, George J. (12)
Kolb, John M. (9)
Kolbe, Joseph T. (6)
Kolodin, Abraham (7)
Kondor, Joseph S. (11)
Konzelman, Henry J. (20)
Konzelmann, Frank W. (1)
Kooperman, Barnett (9)
Kooperstein, Samuel I. (9)
Koplin, Nathaniel H. (11)
Kornfeld, Werner (7)
Kornfield, Norman B. (9)
Kosminsky, Louis (9)
Kossmann, Walter J. (14)
Kosterlitz, Henry H. (7)
Kovaleski, Walter A. (16)
Kovin, Abraham (16)
Kraczyk, Michael J. (4)
Kraemer, Manfred (7)
Kraemer, Samuel H. (9)
Krafchik, Louis L. (12)
Kraissl, Cornelius J. (2)
Kraker, David A. (7)
Kralik, Joseph J. (7)
Kramer, Bernard M. (12)
Kramer, Douglas W. (20)
Kramer, Samuel E. (12)
Krans, DeHart (20)
Krans, Edward S. (20)
Kratka, William H. (6)
Krauss, Fletcher I. (14)
Krausz, Emery (21)
Kraut, Arthur M. (9)
Krechmer, Abraham (1)
Kresch, Philip (9)
Kreutz, Paul J. (20)
Krichbaum, Carroll E. (7)
Krieger, George (16)
Krone, William F. (7)
Kruger, Alfred L. (9)
Kruger, William (7)
Krugman, Benjamin (16)
Kuchlewski, Edward J. (20)
Kuder, Joseph M. (3)
Kuhlmann, Alvin E. (9)
Kuite, George B. (14)
Kummel, Max (7)
Kump, Albert B. (6)
Kun, Bertram (9)
Kunz, Harold G. (7)
Kuperman, Henry L. (7)
Kushner, Alexander (20)
Kustrup, John F. (11)
Kutner, Charles (4)
Kwint, Joseph A. (20)
Kyle, Ernest I. (20)

ASSOCIATE MEMBERS

Kaletkowski, Marion F. (16)
Kearney, Paul A. (7)
Kimche, Irwin (7)
Koch, James (7)
Koch, William (13)
Koenig, Robert E. (12)
Korman, Arnold (16)
Kren, Frank (11)
Kunderman, Philip J. (12)

L

ACTIVE MEMBERS

Laauwe, Harold W. (16)
La Barba, Peter J. (2)
Labow, Joseph J. (20)
Ladas, George (20)
Lafferty, Elton B. (7)
Lakiszak, Roman T. (9)
Lamberto, Vito A. (2)
Lance, Elton W. (20)
Landaw, Louis (16)
Landes, Edwin W. (19)
Landesman, William (7)
Landis, Harry P., Jr. (3)
Landry, Ernest J. (20)
Landshof, Charles A. (9)
Lane, Austin W. (7)
Lane, Edgar W. (10)
Lane, Thomas F. (9)
Lang, Joseph (12)
Lang, Louis (20)
Lange, Louis C. (9)
Langston, Junius T. (20)
Lapin, Louis P. (11)
Lapin, Samuel B. (11)
Larkey, Irving G. (7)
Larossa, Ernest A. (4)
Larrabee, Callie H. (20)
Larson, Henry M. (14)
Larsson, Evert A. (11)
Lashman, William M. (4)
Lathrop, Frederic W. (20)
Lathrope, George H. (14)
Latona, Joseph A. (2)
Laudig, Guy H. (14)
Laurie, Andrew L. (20)
Lavine, Barney D. (11)
Lavine, Samuel C. (12)
Lavine, Sidney B. (11)
Lawless, Edward T. (7)
Lawrence, Arthur C. (16)
Lawrence, Elias D. (16)
Lawrence, William H. (20)
Lawsing, G. Conde (9)
Lawther, Boyd M. (1)
Lawton, A. Anderson (18)
Lazow, S. Manlius (12)
Leach, John E. (16)
Leaman, Granville M. (7)
Leaver, Morris H. (10)
Le Bel, Louis J. B. (7)
Leber, Otto H. (7)
Lee, Benjamin F. (4)
Lee, Frederick P. (16)
Lee, John J. (7)
Lee, Robert E. (7)
Lee, Thomas B. (4)
Lee, William A. (9)
LeFavor, Dean H. (3)
Leff, William A. (7)
Lefkovics, Sidney C. (7)
Lefkowitz, Jacob H. (9)
Legato, Samuel F. (2)
Leggett, Lindley H., Jr., (20)
Leggett, Thomas H., Jr. (20)
Lehmacher, Frank (15)
Lehman, David J., Jr. (7)
Leining, Albert (9)
Leir, J. Krevin (9)
Lemay, Albert T. (16)
Lemkin, Samuel (7)
Lemmerz, Willard H. (2)
Lemmon, Junius M. (21)
Lempke, Richard J. (9)
Leonard, George F. (12)
Leonard, Isaac E. (1)
Leonard, Isaac E., Jr. (1)
Lepis, A. Albert (9)
Lepree, Joseph A. (20)
Lerman, Irving (20)
Lerman, Samuel (20)
Leshin, Harry (11)
Lesko, Stephen W. (2)
Lettiere, Anthony J. (11)
Levin, Jack (13)
Levin, Joseph (7)
Levin, Louis (11)
Levin, Murray (7)
Levine, David B. (16)
Levine, Edward P. (7)
Levine, G. Irving (9)
LeVine, Israel (16)
Levine, Philip (7)
Levine, Sidney C. (16)
Levinsohn, Sandor A. (16)
Levinson, David M. (7)
Levinson, Louis J. (7)
Levinson, Reuben (12)
Levinson, Robert M. (7)
Levison, William (7)
Levitas, Irving M. (2)
Levitt, Jesse N. (7)
Levy, Abram (18)
Levy, Anna L. (7)

Levy, David (16)
Levy, Herman (16)
Levy, Irvin (11)
Levy, Jack D. (2)
Levy, Julius (7)
Lewandowski, Edmund E. (7)
Lewis, Albert (20)
Lewis, Alexander (20)
Lewis, Alice B. (2)
Lewis, Collins E. (12)
Lewis, G. Rae (7)
Lewis, Jacob (13)
Lewis, Leon (7)
Lewis, Thomas K. (4)
Liana, Stephen M. (16)
Liccese, Emanuel (7)
Licks, Frederick C. (7)
Liddell, Raymond N. (18)
Liddy, Frank J. (2)
Lieb, Saul (7)
Lieberman, David P. (20)
Lieberman, Milton L. (20)
Lief, Lawrence H. (12)
Liegner, Ben (7)
Light, Arthur B. (11)
Lilien, Bernard B. (7)
Lilien, Milton (7)
Lilien, Milton M. (20)
Lima, John G. (16)
Linares, A. Carfi (16)
Lincoln, Jennings S. (7)
Lind, Zoltan H. (12)
Linden, Mortimer H. (9)
Lindroth, Lawrence V. (9)
Linke, James J. P. (20)
Lipkin, Isadore (17)
Lippincott, Lansing Y. (20)
Lippman, Harold (7)
Lipshutz, Benjamin (9)
Lipshutz, Charles (9)
Lipstein, William (7)
Lipton, Louis (16)
Lisanti, Gaetano (9)
Little, William R. (11)
Littwin, Charles (2)
Liva, Arcangelo (2)
Liva, G. Albin (2)
Liva, Paul F. (2)
Livengood, Baxter A. (8)
Livengood, Horace R. (20)
Livingston, Bernard (7)
Livingston, Paul (7)
Lloyd, Samuel J. (11)
Llull, Gabriel J. (20)
Lobban, Robert B. (9)
Lobsenz, Nathan P. (16)
Locke, Henrik W. (4)
Loder, Horace B. (6)
Loder, Joseph S. (7)
Loeb, William A. (18)
Loeser, Lewis H. (7)
Loksa, Harold T. (14)
Loman, Samuel G. (2)
Lomauro, James R. (16)
Lombardi, Frank L. (2)
Lomhoff, Irving I. (7)
London, Jules R. (16)
London, Leslie (16)
London, William (12)
Londrigan, Joseph F. (9)
Londrigan, Joseph F., II (9)
Long, John F. (7)
Long, Miles T. (9)
Long, Pauline A. (12)
Longnecker, John E., Jr. (19)
Longo, James J. (7)
Longsdorf, Harold E. (3)
Longshore, Walter E., Jr. (7)
Loper, John C. (6)
Lord, C. Donald (2)
Lore, Harry E. (6)
Lorenze, Edward J. (7)
Lorenzo, Michael J. (13)
Losada, Camella A. (20)
Love, Elizabeth F. (3)
Lovell, John F. (7)
Lovett, Joseph C. (4)
Low, Donald B. (16)
Lowell, Milton E. (20)
Lowenstein, Aaron (7)
Lowenstein, Ernest C. (20)
Lowenstein, Harry A. (7)
Lowits, Otto (7)
Lowrey, James H. (7)
Luban, Benjamin (7)
Luca, Frank (13)
Luca, Mildred O. (13)
Lucas, W. Fred (3)
Lucent, S. Bell (16)
Lucey, James J. (12)
Luczynski, Edward W. (9)
Ludlum, Walter D. (20)
Lufburrow, Charles B. (20)
Luippold, Eugene J., Jr. (14)
Luksteid, Casimir J. (16)
Lummis, Clarence P. (17)
Lundblad, Walter E. (7)
Luongo, Federico (7)
Lupin, Edward E. (9)
Lupo, Domenico (7)
Luria, Sanford A. (2)
Lurie, Solomon I. (7)
Lurie, Wolf (7)
Lushear, Frank H. (19)
Lutz, William M. (7)
Lycrly, James M. (20)
Lynch, Albert E. O. (7)
Lynch, Donald C. (11)
Lynch, Edward T. (20)
Lynch, Maurice M. (2)
Lynch, Michael F. (20)
Lynch, Roland J. (9)
Lynn, Hugh B. (7)
Lynn, Irving I. (9)
Lyon, Charles H. (21)
Lyon, Earl C. (6)
Lyons, James V. (7)
Lyons, Romola L. K. (2)

ASSOCIATE MEMBERS

Lang, Richard E. (16)
Lapin, Mathew R. (11)
Legg, George E. (16)
Lieb, Robert L. (7)
Linz, Curt (7)
Lippman, Nathan L. (1)
Lohman, Herman (7)
Lombardo, Bartlo (7)
Long, Elias E. (13)
Lowe, Louise (2)

M

ACTIVE MEMBERS

Maas, Max A. (7)
Mabey, J. Corwin (7)
MacAlister, William W. (16)
MacAlpine, Kenneth B. (4)
Macaluso, Dominic C. (7)
MacArt, James H. (7)
MacArthur, Clymont (7)
Macaulay, Francis A. (2)
MacBrayer, Reuben A. (20)
Macchia, Benjamin J. (9)
MacDermid, Lynden E. (11)
MacDonald, Edward O. (20)
Macdonald, Wentworth S. (7)
Mace, Margaret (5)
MacGahan, William H. (16)
MacGregor, Allan W. (16)
MacGuffie, Robert N. (16)
Machkowsky, Edwin (9)
MacKellar, James M. (2)
MacKenzie, Robert A. (13)
Mackes, Claude B. (17)
Mackin, John J. (9)
Mackler, Harry S. (20)
Mackler, Meyer E. (16)
MacLaren, Philip J. (2)
Maclay, Joseph A. (16)
MacMillan, C. Wright (7)
Macpherson, Elwood H. (7)
Madaras, John S. (9)
Maddren, Russell F. (2)
Mader, A. Ivan, Jr. (2)
Madison, L. Kelth (9)
Maffongelli, Joseph A. (16)
Magee, Edward S. (4)
Magee, Harold S. (11)
Magee, Russell S. (4)
Maggio, George A. (7)
Maggio, Nicholas A. (7)
Maggio, Ross J. (20)
Magill, Marcus (1)
Magnes, Max (16)
Magolda, Anthony F. (6)
Magovern, Thomas F. (7)
Magson, Albert E. (11)
Mahaffey, J. Lynn (4)
Maher, John E. (13)
Mahoney, Thomas H. (2)
Mahood, Herbert L. (7)

Maisel, Irving (7)
Majeski, Henry J. (11)
Major, Morton M. (1)
Makin, John B. (13)
Malatesta, Charles S. (20)
Maldeis, Albertos M. K. (4)
Mallison, Herbert (20)
Mamlet, Alfred M. (7)
Manahan, Daniel V. (13)
Maneene, Edward M. (2)
Mancusi-Ungaro, Elviro (7)
Mancusi-Ungaro, Lodovico (7)
Manette, Milton (9)
Manfro, Gerard J. (7)
Mangogna, Philip (12)
Mangone, Edith (9)
Mangone, George F. (9)
Mann, Benjamin (12)
Mann, Jacob J. (12)
Manser, Ernest E. (4)
Manzione, Frank A. (16)
Maps, Howard L. (16)
Marcarian, Henry G. (4)
Marchione, Nicholas E. (6)
Marcus, Bernard (18)
Marcus, Donald (7)
Marcus, Kurt (9)
Margaretten, Edward I. (12)
Margolis, Alfred (7)
Margulies, Charles (7)
Marin, Robert B. (7)
Marini, Dominick (16)
Mark, Harold I. (2)
Mark, Harry B. (3)
Mark, Joseph S. (12)
Markel, Albert G. (16)
Markley, Luther A. (2)
Markowitz, Irwin B. (9)
Markowitz, Isidor (5)
Markowitz, Louis (16)
Marks, Zelda I. (7)
Marlett, Neumann C. (21)
Marone, Carmine R. (20)
Maroney, James H. (20)
Marquis, Dean W. (7)
Marquis, W. James (7)
Marra, Rocco S. (7)
Marrella, Louis F. (9)
Marrocco, William A. (16)
Marshall, Frank A. (9)
Marshall, H. Donald (1)
Martin, Leonard J. (13)
Martin, Theodore (16)
Martin, William (4)
Martin, William P. (7)
Marts, George H. (20)
Marvel, Peter H. (1)
Marvin, Dorothy H. (12)
Marx, Frederick J. (2)
Masciocchi, Thomas A. (7)
Mason, Alvin S. (17)
Mason, James H. (1)
Mason, Virgil A. (7)
Massengill, Fulton (7)
Massey, J. Bruce (7)
Masterson, John F. (7)
Mastroianni, Frank M. (20)
Mastromonaco, Joseph D. (9)
Masucci, Alberico (16)
Matheke, George A. (7)
Matheke, Otto G. (7)
Matheke, Otto G., Jr. (7)
Mathesheimer, Jacob L. (9)
Matheson, Gilchrist E. (7)
Mathews, Raymond H. (14)
Mathews, William J. (9)
Matthews, Clifford B. (7)
Matthews, Leonard M. (16)
Matthews, William (13)
Matthews, William F. (7)
Maturi, Vincenzo E. (9)
Mauer, Richard E. (7)
Maurer, K. Virginia (7)
Maurer, Martha E. (20)
Mautner, Emil (7)
Maver, William W. (9)
Maxwell, Carl A. (21)
May, Ernst A. (7)
Mayhew, Charles H. (6)
Mazzarella, Carlo (16)
McAlpine, Paul (20)
McAveney, Thomas F. G. (7)
McBride, Andrew F., Jr. (16)
McBride, Hesser G. (7)
McCall, Jesse (19)
McCallion, William H. (20)
McCandliss, William K. (11)
McCarroll, E. Mae (7)
McCarron, James A. (9)
McCarthy, Arthur M. (4)
McCarthy, George L. (16)
McCarthy, John J. (9)
McCarthy, William P. (11)
McCauley, Francis J. (7)
McClintock, Elsie (20)
McCluskey, Harry B. (14)
McConaghy, Thomas P. (4)
McCorkle, William E. (10)
McCormack, Frank C. (2)
McCormick, James E. (7)
McCormick, William H., Jr. (12)
McCreight, David W. (13)
McCroskery, James H. (7)
McCue, John B. (16)
McCullough, John H. (11)
McCullough, Walter A. (7)
McDermott, Vincent T. (4)
McDonald, Richard J. (16)
McDonnel, Gerald E. (3)
McDonnell, George J. (13)
McFeely, Percy R. (2)
McGeary, John A. (20)
McGeehan, Stanley M. (1)
McGinn, William J. (20)
McGlade, Thomas H. (4)
McGovern, John F., Jr. (12)
McGuigan, Francis A. (11)
McGuire, John J. (7)
McGuire, William A. (8)
McIlveen, Marion (2)
McKelvie, Julius C. (13)
McKeown, George H. C. (7)
McKiernan, Robert L. (12)
McKim, William F. (7)
McKinstry, John W. (12)
McLane, A. Donald (2)
McLaughlin, Thomas F. (12)
McLean, Hugh A. (9)
McLellan, George A. (7)
McLeod, Harry J. (2)
McLeod, Neill S. (12)
McLoughlin, Frank J. (9)
McLoughlin ,John W. (9)
McMahon, Bernard C. (14)
McMurray, George B. (14)
McMurtrie, William A. (14)
McNenney, Claudio E. (9)
McPherson, Malcolm E. (16)
McTague, Robert S. (13)
McVay, Edward A. (7)
McVeigh, Charles J. D. (19)
McWilliams, Charles E. (4)
Meacham, Eugene A. (12)
Means, Paul B. (11)
Mears, William G. (2)
Mecray, Paul M. (4)
Mecray, Paul, Jr. (4)
Medd, John C. (7)
Meehan, George E. (9)
Meehan, Martin M. (7)
Meeker, Irving A. (7)
Meeker, John L. (20)
Megibow, Harold J. (2)
Meier, William U. (16)
Meineke, William C., Jr. (20)
Meinhard, Fred (7)
Meinzer, Martin S. (12)
Meisel, David B. (7)
Mellen, Stanley H. (7)
Meloney, Lester F. (16)
Meltsner, Louis (9)
Meltzer, Louis (9)
Melvin, Daniel G. (14)
Mendenhall, Clinton D. (3)
Meneve, Alfred D. (16)
Menge, Carl H. (15)
Menk, Paul E. (7)
Mensch, Harvey G. (20)
Merendino, Anthony G. (1)
Merkelbach, Walter P. (7)
Merliss, Eugene (7)
Merlo, Francis A. (20)
Merlo, Francis V. (20)
Mermod, Camille (7)
Merrick, Evelina (7)
Merrill, Charles F. (12)
Merrill, Edwin D. (10)
Merselis, John G. (7)
Mersheimer, Christian H. (9)
Messina, Thomas (7)
Messinger, Samuel (12)
Metsky, Joseph (7)
Metz, Henry (2)
Metzer, Emma P. W. (3)
Metzer, Freeman W. (3)
Meurlin, Alfred (7)
MeVay, James C. F. (1)
Meyer, Eugene A. (3)
Meyer, George P. (4)
Meyer, Howard M. (2)
Meyer, William (9)
Meyers, Francis R. (16)
Meyerson, Noah (9)
Mezzetti, Alfred F. (6)
Michell, George E. (21)
Michelson, Henry (16)
Mick, Edwin C. (7)
Mickewich, Stephen A. (9)
Miele, Frank A. (13)
Mierau, Ernest W. (7)
Milano, Cesare A. (1)
Miller, Earle K. (11)
Miller, George M. (12)
Miller, Gerald H. (11)
Miller, H. Garrett (6)
Miller, Herbert G. (2)
Miller, Herman P. (7)
Miller, I. Irwin (7)
Miller, Joseph A. (7)
Miller, Lewis H. (17)
Miller, Lucille F. (7)
Miller, Nathan (7)

Miller, Ralph (7)
Miller, Reginald C. (11)
Miller, Robert B. (9)
Miller, Robert M. (20)
Miller, S. David (12)
Miller, S. Thomas (13)
Miller, Samuel R. (11)
Miller, Theodore R. (7)
Miller, William H. (17)
Milligan, Robert S. (20)
Milliser, Estelle T. (20)
Mills, Charles S. (3)
Mills, Clifford (14)
Mills, Stephen D. (20)
Minard, Edwy L. (7)
Minier, Carl L. (7)
Miningham, William D. (7)
Minnefor, Charles A. (7)
Minnella, Thomas J. (20)
Minschwaner, Geo. G., Jr.. (11)
Mintz, Alvin R. (9)
Miranti, Paul J. (9)
Mishell, Daniel R. (7)
Mishler, Jay E. (1)
Misko, Albert (18)
Missonellie, William (16)
Mitchell, Augustus J. (7)
Mitchell, Charles H. (11)
Mitchell, Charles R. (16)
Mitchell, Walter L., Jr. (7)
Mitskas, Theodore V. J. (11)
Modarelli, Walter H. (9)
Modeski, Chester J. (7)
Modrys, Walter F. (2)
Moeckel, Clarence W. (7)
Mohair, John P. (13)
Mohr, Frank L. (20)
Molitch, Matthew (1)
Monaco, Dante P. (7)
Monaco, Saverio A. (7)
Monaloy, Morris A. (16)
Moncada, Salvatore (7)
Monfort, Robert N. (9)
Monica, Louis A. (9)
Monosson-Friedland, Ida (5)
Moon, Alexander C. (5)
Moore, Dean C. (7)
Moore, James A. (7)
Moore, Ralph L. (8)
Moran, John F., Jr. (10)
Mores, Herbert R. (2)
Moress, Edward J. (7)
Moretti, John J. (7)
Morgan, Browne (7)
Morganstein, Louis K. (9)
Moriarty, John F. (9)
Morici, Theodore (16)
Moriconi, Albert F. (11)
Morley, Grace C. (9)
Morrill, James P., Jr. (16)
Morris, Carlyle (12)
Morris, Charles W. (17)
Morris, Karl E. (20)
Morris, Nathan (18)
Morris, Thomas M. (20)
Morris, Watson B. (20)
Morrison, Frederick H. (19)
Morrow, Joseph R. (2)
Moscoe, Harry A. (16)
Moss, Jack W. (2)
Moss, Mary C. (7)
Mott, Joseph E. (16)
Motzenbecker, Peter F. (7)
Mount, Walter B. (7)
Mountford, William E. (11)
Muccia, John J. (9)
Mueller, George H. (9)
Muldoon, Edward J. (3)
Muller, Frederick L. (2)
Muller, Joseph H. (7)
Mulligan, Edward W. (13)
Mulligan, Luke A. (2)
Mullin, Eugene F. (7)
Mullins, Roy L. (10)
Mulvihill, William J. (9)
Munger, Ray T. (20)
Munro, Charles A. (3)
Munro, Jeannette (11)
Murn, Charles J. (16)
Murphy, Charles M. (13)
Murphy, Herschel S. (20)
Murphy, James A. (11)
Murphy, James M. (9)
Murphy, Thomas W., Jr. (7)
Murray, Clifford K. (1)
Murray, Edwin N. (4)
Murray, Harrold A. (7)
Murray, Joseph A. (9)
Murray, Norman L. (20)
Murto, Thomas V. (11)
Musetto, Carmelo A. (14)
Mustermann, Otto H. (9)
Muta, Samuel A. (7)
Muttart, George W. (9)
Mutter, Alfred A. (9)
Myatt, Leslie E. (6)
Myers, Norman V. (2)

ASSOCIATE MEMBERS

Magee, William P. (2)
Mancusi-Ungaro, Harold (7)
Marino, Benjamin (12)
Marshall, Irving (11)
Mather, William B. (11)
McCracken, Josiah C., Jr. (1)
McCurdy, Robert G. (13)
McGahn, Joseph (1)
McWhorter, John E. (2)
Mele, Vincent (7)
Merk, Anthony (7)
Mitchell, Willis B. (15)
Morrow, Charles S. (1)
Morton, Thomas V., Jr. (7)

N

ACTIVE MEMBERS

Nacca, Carl A. (7)
Nadel, Charles I. (7)
Nadler, Arthur A. (20)
Nafash, Shafeek (9)
Nafey, Herbert W. (12)
Nagler, Benedict (7)
Naidorff, Saul A. (20)
Nappi, Pasquale E. (7)
Nash, Alexander E. (7)
Nash, Herman S. (7)
Nataro, Joseph (7)
Nataro, Maurice (7)
Naulty, Charles W., Jr. (12)
Navazio, Attilio (14)
Nayfield, Romald C. (11)
Neal, Charles B. (6)
Neary, Edward R. (2)
Neer, William (16)
Neiderhoffer, Sydney L. (13)
Nemirow, Martin (16)
Nemzek, William P. B. (7)
Nesbitt, Elizabeth (16)
Netz, Lester W. (2)
Neumann, Alfred (20)
Neville, Robert J. (2)
Nevius, William B. (7)
Newbury, Graham C. (20)
Newcomb, Marcus W. (3)
Newman, Grace T. (7)
Newman, Julius (7)
Newmeyer, Joseph (3)
Ney, J. Marshall (7)
Nichols, Frank I. (2)
Nichols, Stanley H. (13)
Nicholson, Frank P. (9)
Nickman, E. Harrison (1)
Nicol, Lorenz C. (2)
Nicola, Toufick (7)
Nicoll, George L. (14)
Nieman, Solomon Z. (12)
Niemtzow, Frank (13)
Nimaroff, Meyer (7)
Nittoli, Rocco M. (20)
Nobile, James J. (9)
Noll, Louis (7)
Nonziato, Frank A. (11)
Normand, Alphone F. (12)
Norris, Alfred W. (16)
North, Harry R. (11)
Norton, James F. (9)
Norval, William A. (16)
Norwich, Louis E. (9)
Notkin, Meyer (16)
Noto, Philip (16)
Novello, Joseph A. (20)
Novich, Max (7)
Nuse, Edward F. (9)
Nussbaum, Harvey E. (7)
Nussbaum, Joseph (20)
Nye, Howard H. (16)
Nyirl, William A. (7)
Nyvall, Pierre J. (15)

ASSOCIATE MEMBERS

Naame, John M. (1)
Nathanson, Norman (13)
Nussbaum, Nathan (16)

O

ACTIVE MEMBERS

Oberlander, Gertrude (7)
Obert, J. Edwin (15)
Obester, Gabriel E. (20)
O'Brian, Dennis M. (16)
O'Brian, Jeremiah H. (16)
O'Brien, Edwin J., Jr. (20)
Ockene, Abraham (9)
O'Connell, James J. (12)
O'Connor, Bernard A. (7)
O'Connor, Dennis F. (7)
O'Connor, John J. (9)
O'Connor, Michael J. (7)
O'Connor, Paul A. (7)
O'Crowley, Clarence R. (7)
Oderr, Charles (20)
Oesterlin, Ernst J. (1)
Öffenkrantz, Frederick M. (7)
Ogden, Andrew E. (11)
Ogden, Michael A. (16)
O'Grady, Michael J. (7)
Okin, Irving (16)
Olini, Joseph J. (7)
O'Lini, Louis J. (7)
Olpp, Archibald E. (9)
Olpp, John L. (2)
Olson, Vendela E. (2)
Ondovchak, M. Frederic (4)
O'Neill, Charles L. (7)
O'Neill, Charles L., Jr. (7)
O'Neill, Gonzalo, Jr. (7)
O'Neill, Joseph F. (11)
Opdyke, Gordon M. (7)
Openchowski, Mieczyslaw (7)
Opfermann, John L. (13)
Opper, Philip (16)
Oram, Joseph H. (16)
Oransky, Marvin (7)
Oren, Hyman (2)
Orloff, Samuel (7)
Ormsby, Thomas J. (7)
Ornaf, I. Edward (4)
O'Rourke, James J. (11)
Orris, Harold J. (7)
Ortolano, James J. (9)
Orton, Foster (20)
Orton, George L. (20)
Orton, Henry B. (7)
Orton, Stuart (20)
Osborn, A. Downey (13)
Osborn, Edward G. (4)
O'Shea, John J. (9)
Osher, Morris M. (20)
Oshrin, Henry (9)
Ostrowski, Sigismund J. (7)
O'Sullivan, John R. (9)
Outwin, Richard N. (7)
Owen, Philip (20)

P

ACTIVE MEMBERS

Padden, Aloysius F. (2)
Paddock, Royce (7)
Pagano, Peter (2)
Pagliughi, John J. (9)
Palazzo, William L. (14)
Palladino, Alessandro (6)
Pallen, Conde deS. (2)
Palma, Nicholas (16)
Palmer, Francis R. (16)
Palmer, Gideon H. (7)
Palmer, Henry S. (7)
Panigrosso, Louis R. (12)
Panitch, William (7)
Pannullo, John N. P. (7)
Pansy, Abraham A. (12)
Pantaleone, Joseph (11)
Papera, John J. (7)
Parell, George C. (7)
Parent, Sol (7)
Paris, William (16)
Parker, Albert F. (17)
Parker, Horace N. (11)
Parker, John E. (7)
Parkes, Morey (7)
Parry, Allen A. (14)
Parry, Antoinette R. (14)
Parry, Oliver K. (13)
Parsonnet, Aaron E. (7)
Parsonnet, Eugene V. (7)
Pascall, Thomas M. (7)
Pasternack, Elroy (16)
Pastore, Mario (6)
Patella, Fulvio (16)
Patterson, Isaac N. (8)
Patti, Frank A. (2)
Pattyson, Ralph A. (7)
Paul, George A. (7)
Paul, H. Carl (7)
Paulson, Arch M. (20)
Pavia, John R. (7)
Payne, Guy (7)
Payne, Guy, Jr. (7)
Peacock, Arthur B. (3)
Pearl, Sydney S. (20)
Pearlstein, Frank (9)
Pearson, J. Gerald (12)
Pearson, Theodore A. (18)
Peckman, Abram (9)
Pecora, Carmine L. (15)
Pecora, Samuel (7)
Pedevill, Joseph R. (2)
Pedrick, William W. (8)
Peer, Lyndon A. (7)
Pegau, Paul M. (8)
Pellegrini, Vincent J. (2)
Pellet, Thomas L. (19)
Pellicane, Anthony J. (12)
Pelliciari, Donald (7)
Penchansky, Samuel J. (9)
Pendexter, Sidney E. (7)
Pennington, Alfred W. (7)
Pennington, John (1)
Pentecost, Salvador D. (7)
Pepe, Salvatore A. (11)
Perelman, Julius S. (7)
Perez, John F. (1)
Perham, Bertram S. (7)
Perham, Roy G. (2)
Perkel, Louis L. (9)
Perlberg, Harry J. (9)
Pernetti, Anthony M. (16)
Perrine, Cornelius C. (13)
Perrone, Anthony J. (7)
Perrone, Arthur F. (9)
Perrotta, Anthony J. (13)
Perry, Frank L. (17)
Pessel, Johannes F. (11)
Peters, Menelaus (9)
Peters, Richard C. (20)
Peterson, Charles A. (9)
Peterson, Walter R. (11)
Petinga, Thomas J. (1)
Petry, William (7)
Pettit, Harry H. (2)
Pettit, Herschel (5)
Phelps, James E. (16)
Phillips, Algernon A. (7)
Phillips, Walter (2)
Piasecki, Chester A. (16)
Pieper, Howard C. (13)
Pierce, Henry A. (2)
Pierson, Carl L. (11)
Pierson, Joseph R. (11)
Pietri, Raoul (13)
Pignataro, Frank P. (13)
Pigott, Albert W. (18)
Pike, Charles E. (4)
Pilch, Arthur G. (7)
Pilkington, Albert (1)
Piller, Jacob (16)
Pilloni, Louis (7)
Piltz, George F. (9)
Pinckney, Frank H. (14)
Pincus, Isidore (7)
Pindar, Arthur W. (2)
Pindar, Frederick S. (9)
Pindar, Irene D. (2)
Pinerman, Robert B. (11)
Pingitore, Eufelia (2)
Pink, Solomon H. (16)
Pino, Anthony (6)
Pinsky, Harry A. (4)
Pinto, Joseph A. (7)
Piskorski, Abdon V. (9)
Pitman, Mason W. H. (18)
Pittman, Allen R. (11)
Pizzi, Francis W. (7)
Pizzi, Mario V. (7)
Pizzi, Peter J. (2)
Placa, James A (2)
Plant, James S. (7)
Platt, Edward V. (4)
Platt, Thomas H. (12)
Plavin, Nathan J. (9)
Pleasants, Edward N. (13)
Plinke, Fritz W. (16)
Plume, Clarence A. (14)
Podell, A. Alfred (13)
Pogoloff, Samuel H. (18)

Pois, John (7)
Poland, George A. (1)
Polaner, George (7)
Poleshuck, Rubin (20)
Policastro, Nelson C. (2)
Polizzotti, Joseph L. (16)
Polk, Charles C. (20)
Pollack, Louis (20)
Poller, Frederick K. (7)
Pollis, Nicholas L. (7)
Pollock, Samuel L. (14)
Pollock, Theodore (16)
Polow, Benjamin (7)
Polowe, David (16)
Pomeranz, Raphael (7)
Pons, Carlos A. (13)
Pontery, Herbert B. (9)
Potter, Benjamin P. (9)
Potter, Charles W. (21)
Potter, Ellen C. (11)
Potter, Raymond T. (7)
Pottinger, William E. (14)
Powis, Ethel M. (11)
Poyas, Morton L. (11)
Prager, Bert A. (14)
Prather, Charles G. (2)
Prather, John W. (2)
Pratt, Arthur G. (4)
Prazak, Beatrice (20)
Preece, John D. (11)
Pregnall, James P. (13)
Preminger, Max (20)
Prestifilippo, Silvestro (7)
Preston, Perry B. (7)
Price, Charles W. (7)
Price, H. Preston (9)
Price, Henry S., Jr. (4)
Price, Nathaniel G. (7)
Prigger, Edward R. (17)
Prince, Robert A. (16)
Prince, Samuel (9)
Principato, Roberto (4)
Probst, Everett W. (7)
Proctor, Francis E. (11)
Proctor, Jesse E. (7)
Protzman, Thomas B. (2)
Proudfoot, Perry A. (20)
Prout, Thomas P. (20)
Prout, William B. (2)
Provisor, Benjamin (16)
Purcell, Ernest F. (11)
Purdy, Charles H. (9)
Pyle, Wallace (9)

ASSOCIATE MEMBERS

Palmeri, Anthony (16)
Pramuk, Clarence (2)
Prunetti, Carman (11)
Putter, Eric (12)

Q

ACTIVE MEMBERS

Quackenbos, Harrie M. (11)
Quad, Clifford W. (7)
Quigley, Frederic J. (9)
Quinn, Edward D. (7)
Quinn, John J. (9)
Quinn, Norman J. (1)
Quirk, Martin A. (13)

R

ACTIVE MEMBERS

Raab, Michael (16)
Rachlin, Harry T. (7)
Rachunis, Michael (3)
Raez, George (12)
Rader-Hoheb, Katherine A. (2)
Radest, Louis J. (16)
Rados, Andrew (7)
Raffetto, Joseph F. (13)
Ragany, Joseph (11)
Rainey, Willard G. (11)
Ram, Nathan H. (7)
Rampona, Joseph M. (11)
Ramsey, F. Muriel (6)
Randazzo, Anton P. (16)
Ranson, Briscoe B., Jr. (7)
Rapalski, Adam J. (7)
Rapp, Robert F. (4)
Rappaport, Doris I. (2)
Rathgeber, Charles F. (7)
Rauschenbach, Paul E., Jr. (16)
Ravits, Everett O. (2)
Ravitz, Samuel F. (7)
Rawitz, Sidney B. (7)
Re, Natale M. (2)
Read, Hilton S. (1)
Read, Jessie D. (20)
Read, William T., Jr. (4)
Reading, H. Eugene (16)
Reale, Frank P. (20)
Reale, Nicholas P. (18)
Reason, John J. (12)
Reeve-Allen, Jane (7)
Reeves, Ernest (16)
Reeves, J. Franklin (6)
Reich, Abraham L. (7)
Reich, Henry (7)
Reich, Jerome J. (20)
Reich, Mortimer (7)
Reich, Samuel B. (2)
Reid, Erwin W. (2)
Reilly, Christopher J. (7)
Reilly, David F. (20)
Reilly, John V. (7)
Reilly, Joseph (4)
Reilly, Thomas F. (16)
Reinartz, Paul V. (7)
Reiner, David N. (16)
Reiner, Jacob (20)
Reinfeld, Abraham G. (7)
Reinhardt, Warren I. (7)
Reinhold, Herbert E. (2)
Reinhorn, Abraham J. (16)
Reisinger, Paul B. (11)
Reissman, Erwin (7)
Reiter, Walter A. (20)
Reitman, Norman (12)
Relyea, George M. (20)
Remer, Daniel F. (3)
Remondelli, Raphael E. (7)
Renna, Francis (14)
Renner, Clara C. (18)
Renzulli, Francesco (7)
RePass, Paul E. (7)
Repicl, Anthony J. (1)
Resch, Henry U. (7)
Restaino, Charles F. (7)
Rettig, Isidor L. (7)
Revere, Seth D. (7)
Reyner, Daniel C. (1)
Reynolds, Donald G. (13)
Reznikoff, Leon (9)
Rhoads, S. Creadick (8)
Rhone, David S. (4)
Ribbans, Robert C. (7)
Riccobono, Cosmo S. (16)
Rice, Franklin W. (14)
Rich, Charles (7)
Rich, Harry H. (7)
Rich, Wallace E. (7)
Richards, Ernest W. (2)
Richardson, Charles A. (2)
Richardson, Marvin T. (7)
Richmond, Samuel V. (9)
Ricketts, Henry E. (7)
Rieck, Allan (1)
Rieck, Walter R. (9)
Riegert, Louis C. (4)
Rieman, Aloysius P. (9)
Riffin, Irving M. (7)
Rigeron, D. George (7)
Riggins, Edwin N. (7)
Riggs, Vincent J. (7)
Riley, Philetus H. (14)
Rineberg, Irving E. (12)
Ringe, Charles L., Jr. (2)
Ringewald, Robert H. (2)

Rinzler, Elliot (7)
Rinzler, Harry G. (16)
Rinzler, Harvey (15)
Ripley, E. Warren (7)
Rise, Wilson S. (1)
Ristine, Edwin R. (4)
Rita, James J. (11)
Ritter, John J. (16)
Rizzoli, Luigi (7)
Rizzolo, Edward M. (7)
Robbin, Lewis (7)
Robbins, Charles M. (7)
Roberts, Allison H. (7)
Roberts, Charles D. (2)
Roberts, David C. (7)
Roberts, Joseph E., Jr. (4)
Roberts, William A. (7)
Robertson, Eugene V. (16)
Robertson, Euston S. (7)
Robertson, Grace M. (20)
Robie, Theodore R. (7)
Robins, David (7)
Robinson, Anne W. (20)
Robinson, Ernest A. (13)
Robinson, Louis H. (7)
Robinson, William A. (13)
Rocco, Frank (7)
Rodi, Louis M. (1)
Rodman, E. Warren (3)
Roemer. Jacob (16)
Rogers, Dorothy M. (8)
Rogers, Laurence H. (11)
Rogers, Robert H. (7)
Roh, Robert F. (7)
Romano, Anthony M. (2)
Romano, Michael J. (16)
Romano, Patrick J. (7)
Rommer, Jack J. (7)
Rona, Maurice (12)
Roop, William O. (1)
Rosamilia, Ralph E. (7)
Rose, Abraham (20)
Rose, Salvatore J. (7)
Rose, William G. (11)
Roseman, Herman I. (7)
Rosen, Charles D. (7)
Rosen, Charles E. (9)
Rosen, Emanuel (7)
Rosen, Sol (6)
Rosenbaum, Samuel X. (7)
Rosenberg, Albert B. (9)
Rosenberg, Alvin A. (14)
Rosenberg, Jacob (9)
Rosenberg, L. Charles (7)
Rosenberg, Louis (1)
Rosenberg, Max (7)
Rosenblatt, Max B. (20)
Rosenblatt, Sidney (1)
Rosenstein, Jacob L. (9)
Rosenstein, Saivel L. (20)
Rosenthal, Abraham (13)
Rosenthal, Arnold J. (7)
Rosenthal, Bernice D. (6)
Rosenthal, Oscar J. (7)
Rosenthal, Sydney (7)
Rosner, Edwin (4)
Ross, Ira S. (7)
Ross, Peter W. (16)
Ross, Selig J. (2)
Rossi, Bartolomeo (18)
Rossi, Gene (18)
Rossi, John R. (9)
Rost, Adolf S. (7)
Roston, Mark A. (7)
Roth, Ferdinand L. (20)
Roth, Oswald H. (7)
Roth, Samuel R. (7)
Rothfuss, C. Howard (12)
Rothgesser, Jerome C. (7)
Rothhouse, Burnet (7)
Rothschild, Daniel L. (7)
Rothschild, Karl (12)
Rothseid, Abraham (7)
Rowan, Henry M. (11)
Rowe, Jack M. (7)
Rowe, Joseph A. (2)
Rowland, John H. (12)
Rowohlt, George O. (2)
Roy, Bert W. (19)
Roy, Joseph N. (16)
Roylance, F. Dean, Jr. (2)
Rozsa, Stephen (7)
RuBacky, Joseph F. A. (16)
Rubba, Russell R. (1)
Rube, Joseph A. (2)
Rubens, Otto (14)
Rubenstein, Eli (9)
Rubenstein, Robert (9)
Rubin, Abraham A. (7)
Rubin, Adrian D. (13)
Rubin, Benjamin (12)
Rubin, David (20)
Rubin, Harold (13)
Rubin, Henry S. (14)
Rubin, Samuel (14)
Rubin, William (12)
Ruccia, Arthur (7)
Rucker, William C. (2)
Rudolph, John P. (4)
Ruffer, Ralph A. (9)
Rullman, Walter A. (13)
Rumage, William T. (7)
Rumsey, William L., Jr. (20)
Rundlett, Emilie V. (9)
Runnells, John E. (20)
Runyan, William J. (7)
Runyon, Laurence P. (12)
Ruocco, William B. (16)
Ruoff, Andrew C. (9)
Russell, Charles B. (16)
Russell, David L. (9)
Russell, Karl S. (4)
Russo, Dominic T. (18)
Russomanno, Raymond L. (7)
Ruttenberg, Louis (8)
Ruttenberg, Max (4)
Ryley, Harold W. (2)
Ryman, Merlin T. (14)

ASSOCIATE MEMBERS

Reinhard, Louis (1)
Reinkraut, Arthur D. (16)
Rifici, Anthony L. (13)
Rocco, Leo C. (13)
Rogers, James A. (16)
Romano, Frank (12)
Rosenberg, Lillian M. (7)
Rosenberg, Norman (12)
Rosso, John D. (11)
Russomanno, Paul (7)

S

ACTIVE MEMBERS

Sabarese, Theodore C. (16)
Sabini, Cecil F. (9)
Sacco, Anthony G. (9)
Sacco, Gregory E. (13)
Sachs, Wilbert (9)
Sackin, Stanley (11)
Saco, Louis S. (16)
Sadoff, Joseph (20)
Saffron, Morris H. (16)
Sager, Harold (9)
Sagi, Ellen I. (20)
Sakowski, John P. (9)
Sala, Aldo W. (16)
Saladino, Anthony J. (9)
Salaky, William L. (12)
Salasin, Samuel L. (1)
Salmeri, Edward J. (2)
Salmon, Edward F. (9)
Salmon, George G., Jr. (7)
Salsberg, Ralph H. (7)
Salter, Kent (16)
Saltus, Lloyd S. (14)
Salva, Edo J. (2)
Salvati, Leo H. (20)
Salvatore, Joseph T. (11)
Salway, Benjamin (11)
Salzman, Nathan (16)
Samson, Norman D. (7)
Samter, Max (4)
Samuel, Jerome H. (7)
Samuels, S. Lawrence (20)
Sand, Abraham B. (3)
Sandella, Joseph F. (12)
Sandler, Moses (2)
Sandler, Samuel A. (2)
Sanfacon, Thomas A. (16)
Santangelo, Emil L. (16)
Santangelo, Stephen (9)
Santora, Philip J. (7)
Santoro, Thomas A. (7)
Santosky, Benjamin B. (9)
Saporito, Archibald R. (7)
Saracino, Frank J. (7)
Saradarian, Albert V. (9)
Sarajian, Aram M. (2)
Sargent, Eva R. (18)
Sarla, Michael (2)
Sarokhan, Joseph (16)

Saseen, Charles A. (1)
Saslow, Benjamin I. (7)
Saslow, Stella K. (7)
Satulsky, Emanuel M. (20)
Saulsberry, Charles E. (12)
Savage, Charles L. (17)
Savel, Lewis E. (7)
Sawyer, Blackwell (15)
Sax, Max T. (7)
Sayers, Francis P. (17)
Sayre, William D. (13)
Sbarra, Francesco C. N. (7)
Scalera, John F. (7)
Scalessa, Mario F. T. (20)
Scammell, Frank G. (11)
Scanlan, D. Ward (1)
Scasserra, Benedict B. (11)
Scerbo, Ernest (2)
Schaaf, Royal A. (7)
Schaberg, Frank J. (2)
Schachter, Harry A. H. (7)
Schaefer, Eugene P. (7)
Schafer, Marguerite A. (16)
Schaffer, Barney (7)
Schaffer, Nathan (7)
Schall, Reuben E. (4)
Schectman, Vera (7)
Scheffler, Wilhelm A. H. (4)
Schefrin, Alexander E. (16)
Schellenger, Edward A. Y. (4)
Scheller, George A. (7)
Schenk, Joseph R. (20)
Schenker, Benjamin N. (9)
Schenker, Israel N. (9)
Schenker, Sarah S. (9)
Schept, Samuel S. (9)
Scher, Maurice A. (7)
Schildkraut, Jacob M. (11)
Schiller, Edwin (20)
Schiller, Nicholas (7)
Schiller, Rosa O. (20)
Schilling, Anthony B. (20)
Schimenti, Matteo (9)
Schirber, Rene G. (12)
Schiro, S. Robert (2)
Schisler, Milton M. (3)
Schlein, August (9)
Schlein, David (20)
Schlichter, Charles H. (20)
Schlossbach, Theodore (13)
Schlossberg, Ezra (16)
Schmidt, Albert F. (13)
Schmidt, Clifford M. (19)
Schmidt, Walter W. (2)
Schmukler, Jacob (7)
Schneider, Charles A. (7)
Schneider, Clinton R. (15)
Schneider, Harry M. (9)
Schneider, Leo (7)
Schneider, Louis (7)
Schneider, Louis A. (9)
Schneider, Richard C. (7)
Schoenau, Carl W. (7)
Schotland, Clement E. (7)
Schrack, Helen F. (4)
Schram, William S. (18)
Schramm, Joseph A. (7)
Schreck, Harry (7)
Schretzmann, Rudolph C. (2)
Schubert, Roy R. (16)
Schuchner, William F. (9)
Schuck, Trangott J. (9)
Schulsinger, Samuel (7)
Schulte, Herbert A. (7)
Schults, Anna R. (7)
Schultz, Augustin M. (16)
Schultz, Irving A. (2)
Schurman, Francis H. C. (7)
Schwab, George P. (9)
Schwartz, Harold (7)
Schwartz, Harold B. (9)
Schwartz, Henry C. (4)
Schwartz, Jacob R. (16)
Schwartz, Leon J. (6)
Schwartz, Mortimer L. (7)
Schwartz, Ralph A. (7)
Schwartz, Samuel H. (20)
Schwartz, William (16)
Schwartzberg, Frederick I. (16)
Schwarz, Berthold T. D. (9)
Schwarz, Henry J. (9)
Schwarz, Julianna L. (16)
Schwarzkopf, George C. (1)
Schwarzwald, Irving (9)
Schweizer, Roman G. (20)
Schwinn, Charles (1)
Sciarrillo, Louis F. (9)
Scielzo, Nicholas F. (16)
Scillieri, John (2)
Scott, Frederick J. (19)
Scott, Frederick W. (12)
Scott, Harold R. (7)
Scott, John J. (9)
Scott, Leonard G. (6)
Scott, Norman M. (7)
Scott, Parry M. (3)
Scott, Samuel G. (9)
Scranton, Charles W. (7)
Scribner, Charles H. (16)
Scullion, Arthur A. (2)
Sealey, Henry J. (2)
Seely, Roy B. (11)
Segard, Christian P. (2)
Seiberling, Joseph D. (4)
Seidler, Victor B. (7)
Seidman, Edwin A. (7)
Seidman, Joshua I. (7)
Seifert, Edwin A. (7)
Seiler, Benjamin (2)
Seitzick-Robbins, Hannah E. (11)
Sekerak, Albert J. (11)
Seligmann, Fred S. (9)
Selinger, Samuel (9)
Sell, Frederick W. (20)
Sellitto, Anthony M. (7)
Selvaggi, Carlo (7)
Sender, Fannie (12)
Senerchia, Fred F., Jr. (20)
Serri, William S. (8)
Seto, Stanford P. T. (4)
Severud, Olaf J. (2)
Seward, Frederic H. (14)
Seward, William H. (7)
Sewell, Stephen (13)
Sexton, Edward V. (2)
Seybold, Arthur D. (20)
Seymour, Edward T. (2)
Seymour, George A. (20)
Shack, David N. (7)
Shack, Maxwell H. (7)
Shaen, Edward (4)
Shafer, Albert H. (4)
Shafer, F. William (4)
Shaner, Ralph D. (7)
Shangle, Milton A. (20)
Shangold, Jack E. (10)
Shanik, Morton J. (14)
Shanik, William (13)
Shannon, James B. (7)
Shannon, Lardner M. (7)
Shapiro, Charles S. (3)
Shapiro, David (16)
Shapiro, Louis (7)
Shapiro, Louis G. (16)
Shapiro, Max (20)
Shapiro, Ralph N. (7)
Shapiro, Samuel A. (7)
Shapiro, Saul J. (9)
Sharp, Charles E. (6)
Sharp, Reuben L. (4)
Shaul, Frederick G. (7)
Shaul, John F. (7)
Shavelson, Irving C. (1)
Shaw, Ernest B. (4)
Shaw, John J. (7)
Shaw, Ned (7)
Shayevitz, Abraham S. (12)
Sheaffer, Clinton P. (4)
Shear, M. Murray (11)
Shechner, Isadore (7)
Shechtman, Abraham (16)
Sheehan, Daniel C. (7)
Sheets, Cecil C. (8)
Sheft, Matthew J. (16)
Shemeley, William G., Jr. (4)
Shenfeld, Isaac (1)
Sheppard, Alfred G. (6)
Sheppard, Muse A. (6)
Sheppard, Thomas S. (6)
Sherk, A. Lincoln (4)
Sherman, A. Russell (7)
Sherman, Arthur E. (7)
Sherman, Benjamin (14)
Sherman, Byron G. (14)
Sherman, Elbert S. (7)
Sherman, Fuller G. (8)
Sherman, Samuel H. (20)
Sherman, W. Edgar (12)
Shevitz, David M. (21)
Shill, Benjamin (7)
Shimer, Floyd A. (21)
Shinefeld, Maurice A. (16)
Shipman, James S. (4)
Shipman, Meyer P. (16)
Shippee, James N. (16)
Shipps, Hammell P. (3)
Shirlock, Margaret E. (6)
Shirrefs, Russell A. (20)
Shivers, Charles H. deT. (1)
Shlionsky, Herman (7)
Shook, Benjamin E. (9)
Shope, Edward P. (4)
Shor, David M. (7)
Shreehan, Hubert F. (7)
Shull, Elliott C. (4)
Shull, John V. (12)
Shulman, Abraham (16)
Shulman, Murray W. (7)
Shulman, Nathan L. (9)
Shuster, Samuel A. (1)
Sica, L. Samuel (11)
Siciliano, Thomas (16)
Sickel, Emanuel M. (15)
Sieber, Isaac G. (4)
Siegel, Isadore (12)
Siegel, Jack G. (7)
Siegel, Jacob W. (7)
Siegel, Lester (9)
Siegel, Sidney L. (6)
Siemion, Theophilis R. (11)
Sieskind, Richard S. (7)
Sigman, George (9)

Silberner, Herbert B. (7)
Silich, Robert L. (9)
Silk, Charles I. (12)
Sill, John B. (11)
Silon, Milton R. (9)
Silver, E. Drew (11)
Silver, Harry B. (7)
Silvera, Salomon (9)
Silverman, Irving A. (16)
Silverman, R. Louis (17)
Silverman, S. Andrew (7)
Silverman, Theodore M. (20)
Silvers, Homer I. (1)
Silverstein, Benjamin J. (7)
Silverstein, Jacob M. (7)
Simeone, Peter A. (9)
Simkin, Abraham (16)
Simmons, Albert V. (7)
Simms, George F. (7)
Simon, Henry (7)
Simon, Julius J. (16)
Simon, Ludwig L. (7)
Simon, Philip H. (16)
Simonson, Louis (7)
Simpson, David B. (9)
Sims, Richard V., Jr. (20)
Sinexon, Henry L. (8)
Singer, Bella (20)
Singer, Marie J. (2)
Singer, Max (7)
Singer, Sina S. (9)
Sinkinson, Charles D., Jr. (1)
Sinnott, Gerald W. (9)
Sirotta, E. Bernard (8)
Sisson, Nelson W. (7)
Sivolella, Nicholas W. (7)
Skvarla, John A. (2)
Skwirsky, Joseph (7)
Slack, Clarence J. (11)
Slaff, Florence (16)
Slavin, Paul (7)
Sloan, Samuel L. (16)
Slobodien, Benjamin F. (12)
Slocum, Harry B. (13)
Sly, John L. (20)
Smaine, Enrique delC. (2)
Small, E. Lester (3)
Small, Louis (16)
Smalley, Sara D. (7)
Smalzried, Elmer W. (7)
Smarzo, Marjorie M. (7)
Smith, Andrew M. (1)
Smith, Arthur B. R. (9)
Smith, Bertram H. (4)
Smith, Bryan A. (2)
Smith, Byron J. (7)
Smith, Charles H. (7)
Smith, Christopher A. (7)
Smith, Ellis L. (7)
Smith, Elroy W. (16)
Smith, Frank W. (11)
Smith, Harold W. (7)
Smith, Henry G. (7)
Smith, Herman (21)
Smith, Ivan B. (12)
Smith, J. Meredith (21)
Smith, James D. (4)
Smith, John A. (12)
Smith, John V. (12)
Smith, Joseph A. (12)
Smith, Joseph J. (7)
Smith, Leon A. (16)
Smith, Leonard H. (7)
Smith, Marcia V. (5)
Smith, Marshall (12)
Smith, Meyer (9)
Smith, Nehemiah E. (2)
Smith, Sydney F. (12)
Smith, Thayer A. (7)
Smith, Wilbur A. (4)
Snagg, William T. (4)
Snape, William J. (4)
Snavely, Earl H. (7)
Snedecor, Spencer T. (2)
Snegireff, Leonid S. (11)
Snook, Lee O., Jr. (7)
Snyder, James A. (5)
Snyder, W. Jay (9)
Sobel, I. Jerome (16)
Sobin, Julius (7)
Sochacki, Alexander (4)
Sokoloff, Oscar J. (12)
Solk, Arthur G. (7)
Solomon, Harold (7)
Solomon, Louis (9)
Solworth, Lee (2)
Somers, Fred L. (7)
Somers, Williard H. (2)
Sommer, George N. J. (11)
Sommer, George N. J., Jr. (11)
Sonnenberg, Arthur (7)
Sooy, L. Thomas (8)
Sordillo, Anthony (20)
Sorock, Emil M. (7)
Soschin, Samuel J. (7)
Sosnow, Louis M. (2)
Spaldo, John L. (18)
Spallone, Joseph C. (7)
Spano, Frank (9)
Sparks, Paul R. (3)
Spath, William H. (9)
Spencer, Alvan (14)
Spencer, James H., Jr. (19)
Sperling, Irving L. (7)
Spicola, Louis A. (2)
Spiegelglass, Abraham B. (2)
Spillane, Timothy H. (21)
Spinner, Samuel L. (7)
Spirito, Michael W. (20)
Spivack, David (20)
Spivack, Seymour E. (20)
Spohn, Eugene L. (9)
Spradley, Jeems B. (11)
Sprague, Edward W. (7)
Sprague, Seth B. (9)
Spranz, William S. (2)
Spritzer, Theodore D. (12)
Spurgeon, Dorsett L. (19)
Stabile, John A. (11)
Staehle, Richard H. (7)
Stage, Earl DeW. (14)
Stahl, Alfred (7)
Stahl, Charles (7)
Staknevich, John H. (7)
Stamps, G. Ruffin (1)
Stankiewicz, F. Stanley (9)
Stanton, Nathaniel B. (20)
Stark, Jacob (16)
Starr, Benjamin (9)
Starr, George R., Jr. (7)
Stassi, Anthony (2)
Statman, Arthur J. (7)
Staub, E. Milton (20)
Stearns, Thornton (7)
Steel, John M. (11)
Steel, William A. (5)
Steele, Stephen (20)
Stefansin, Frank (9)
Steffens, Charles T. (12)
Stein, Albert (9)
Stein, Emil (20)
Stein, George H. (20)
Stein, Harold M. (16)
Stein, Harriet N. (16)
Stein, Isadore (20)
Stein, Jacob M. (9)
Stein, Joseph M. (4)
Stein, Louis A. (11)
Stein, Martin H. (20)
Stein, William (12)
Steinberg, Benjamin L. (16)
Steinberg, Werner (20)
Steiner, Edwin (7)
Steiner, Herbert (7)
Stephenson, Daniel H. (4)
Stephenson, Gordon A. (20)
Stern, David A. (7)
Stern, Max E. (7)
Stern, Morris H. (16)
Stern, Morton M. (7)
Stetser, Leland M. (4)
Stevens, Merton H. (7)
Stevenson, G. McKay (20)
Stevenson, George S. (13)
Stewart, Edwin F. (13)
Stewart, Irving J. (8)
Stewart, Katherine E. (19)
Stewart, Robert G. (7)
Stewart, Sloan G. (1)
Stewart, Walter B. (1)
Stickles, Lloyd C. (7)
Stier, Howard W. (16)
Stiles, C. Campbell (7)
Stockfisch, Robert H. (9)
Stoddard, Gordon V. (7)
Stokes, Anthony T. (9)
Stokes, Donald E. (7)
Stokes, James S. (16)
Stokes, Joseph (3)
Stokes, S. Emlen (3)
Stoll, George F. (7)
Stolow, Alan A. J. (10)
Stoltz, Raymond R. (16)
Stone, Frank P. (4)
Storaci, Frank S. (11)
Stouter, Francis L. (16)
Strack, Jerome A. (7)
Strack, Vincent J. (7)
Straub, Herbert H. (7)
Straus, Frederick W. (4)
Straus, Max (7)
Strauss, Arthur (13)
Strauss, Clifton J. (20)
Strauss, Frederick (7)
Strauss, Max (7)
Strauss, William T., Jr. (7)
Streen, Morris E. (7)
Strelinger, Alexander (20)
Strenski, John (3)
Strom, Abraham (20)
Stuart, J. Earle (20)
Stuart, William C. (9)
Sturchio, Edoardo (7)
Sturchio, Eugenio (7)
Stybel, Joseph (20)
Subin, Harry (1)
Sucoff, Moses C. (16)
Suesserman, Henry (7)
Suffness, Gustave (20)
Sufrin, Emanuel (4)
Sullivan, Charles J. (12)
Sullivan, John B. (2)

Sullivan, William M., Jr. (16)
Sullivan, William T. (7)
Summerill, Garnett (4)
Summers, Alfred D. (11)
Summey, Thomas J. (3)
Surgent, George W. (16)
Surran, Carl A. (1)
Sussman, Harold (9)
Suter, Harry F. (17)
Sutherland, William W. (16)
Sutnick, Theodore B. (11)
Sutton, Harold L. (7)
Sutton, Joseph G. (7)
Swain, Richard D., Jr. (7)
Swern, Nathan (11)
Swertfeger, Herbert W. (11)
Swiecicki, Martin E. (4)
Swiney, Juliana C. (9)
Swiney, Merrill A. (9)
Symes, Earl R. (7)
Szerlip, Leopold (7)
Szivos, Louis A. (7)
Szold, Norman F. (15)
Szuch, Nicholas (12)
Szymanski, John J. (16)

ASSOCIATE MEMBERS

Sahler, Otto DeP. (13)
Salasin, Robert G. (1)
Salerno, Louis (16)
Schleifer, Arnold (16)
Scovern, Louis (16)
Scudese, Vincent A. (7)
Siegel, Ralph E. (13)
Siegel, Victor (13)
Silber, Irving M. (12)
Silver, Michael W. (16)
Siwek, Stanley (7)
Smith, B. Earl (11)
Smith, DeWitt H. (11)
Smith, Percy L. (11)
Sobol, Herman (7)
Straus, Walter (11)
Sullivan, John A. (2)

T

ACTIVE MEMBERS

Taber, Frederick S. (12)
Taber, Leslie R. (16)
Taff, Harry (7)
Taffet, William (7)
Taft, Herman L. (9)
Talmage, William G. (14)
Tannert, Carl H. (9)
Tansey, W. Austin, Jr. (7)
Taranto, Michael (20)
Tarbell, Harold A. (7)
Tarta, Ciro S. (16)
Tataryan, Hovsep (9)
Tatem, Henry R., Jr. (4)
Tator, Arthur E. (20)
Taylor, Harold W. (2)
Taylor, Malcolm C. (14)
Taylor, Raymond A. (15)
Teeter, Charles E. (7)
Teichholz, Max H. (16)
Tell, M. Edward (16)
Teller, Daniel W., Jr. (14)
Temes, J. Howard (9)
Tenney, Albert S. (7)
Tenney, Luman H. (11)
Tennis, Edgar M. (2)
Tepper, Victor (7)
terKuile, Reinold W. (2)
Terrell, Edward E. (20)
Terreri, D. Joseph (14)
Terwedow, Henry (9)
Terwedow, Walter G. (9)
Teskey, Stanley (14)
Tether, Russell K. (2)
Thalheimer, Edward J. (6)
Thomas, Claude W. (17)
Thomas, George N. (6)
Thomas, Irene O. (16)
Thomas, John H. (7)
Thomas, Leon H. S. (16)
Thomas, Thomas S., Jr. (14)
Thomison, Harry E. (7)
Thompson, Arthur F. (7)
Thompson, Austin B. (7)
Thompson, Edward C. (16)
Thompson, Minturn R. (20)
Thompson, Penrose H. (4)
Thomson, Carroll S. (7)
Thorne, Nathan (3)
Thorne, William P. (16)
Thornhill, Arthur C. (7)
Thornley, William F. (7)
Thornton, P. John S. (18)
Thron, Leopold E. (16)
Tidaback, John D. (20)
Tillis, Herman H. (7)
Tilton, William R. (7)
Timberlake, Baxter H. (1)
Tirrell, C. Malcolm (7)
Tisch, Leon (12)
Toal, Joseph (2)
Tobey, Franklin J. (7)
Tobey, John R. (7)
Toczek, Heinrich A. (7)
Todd, Francis H. (16)
Tolomeo, Martin E. (18)
Tolor, Stanley (20)
Tomec, Otto C. (11)
Tomec, Richard F. (7)
Tomkins, William (16)
Tomlins, Francis I. (2)
Tomlinson, Rolland D. (20)
Tompkins, Grenelle B. (10)
Torppey, John J. (7)
Toth, Elmer F. (9)
Towbin, Adolph (15)
Townsend, John B. (5)
Townsend, Leslie M. (20)
Toy, Calvert R. (12)
Tracy, George T. (3)
Traganza, Robert W. (4)
Trano, Giovanni (20)
Trautwein, Charles F. (7)
Treiber, Benjamin A. (11)
Tretter, Hans L. (11)
Triarsi, Anthony J. (20)
Trippe, Clarence M. (13)
Trippe, Morton F. (13)
Troedsson, Bror S. (7)
Truax, Alfred J. (14)
Tucker, Sidney (12)
Tuly, Ralph (7)
Tunis, Benno B. (7)
Turi, Amedeo E. (7)
Turner, Charles F. (7)
Turner, Isabel B. (2)
Tushnet, Leonard (7)
Tutela, Arthur C. (7)
Tutschulte, Ernest (7)
Tweddel, George K. (16)
Twinem, Francis P. (2)
Twitchell, Adelbert B. (7)
Tymeson, Walter R. (7)
Tyndall, Alice E. (20)
Tyndall, Hugh H. (9)
Tyndall, Martha W. (20)
Tyson, Frances B. (2)

ASSOCIATE MEMBER

Targan, Nathan (1)

U

ACTIVE MEMBERS

Udinsky, Hyman J. (16)
Uhr, Jacques S. (12)
Ulan, Jerome (12)
Ulan, Oscar (7)
Ulmer, Chester I. (8)
Ulmer, D. H. Bartine (3)
Ulvestad, Lawrence E. (7)
Underwood, J. Harris (8)
Urbach, George (7)
Urbaniak, Henry S. (11)
Urbanski, Matthew F. (12)
Urevitz, Abraham (9)
Utens, Max (2)
Utkewicz, Edmond A. (9)
Uzzell, Edward F. (1)

ASSOCIATE MEMBER

Usher, Glenn S. (11)

V

ACTIVE MEMBERS

Vaczi, Stephen (11)
Valentin, Irmgard (7)
Vallario, Frank A. (7)
Vandenberg, Werner (1)
Vanderbeck, James J. (16)
Vanderbeek, Andrew B. (16)
Vanderbeek, Frank B. (16)
Vanderbeek, Stuart W. (2)
Vander Clock, Cornelius (16)
Vandersluis, Harold H. (2)
Vander Veer, H. Garrett (7)
Van Dyke, Joseph S. (2)
Van Eerde, Albert (16)
Van Emburgh, George H. (7)
Van Gieson, Edward J. (7)
Van Mater, John S. (12)
Vann, Dorothea D. (2)
Vann, Felix H. (2)
Vannatta, George W. (7)
Vanneman, Joseph S. (11)
Van Ness, H. Roy (7)
Van Riper, William D. (2)
Van Schott, Gerard J., Jr. (16)
Van Sickle, Albert W. (14)
Van Winkle, Charles I. (2)
Van Winkle, John S. (16)
Vargyas, Joseph C. (12)
Varney, William H. (21)
Varriano, John L. (9)
Vaughan, James M. (4)
Vento, Sebastian J. (11)
Venturo, Ralph C. (8)
Verbeck, George B. (7)
Vermes, Leslie (19)
Vermeulen, Abram (16)
Vernaglia, Anthony P. (16)
Vespignani, Pasquale (9)
Vilardo, Ross (2)
Villanova, Ralph N. (7)
Villapiano, Joseph G. (13)
Vincent, Nicholas F. (7)
Vinciguerra, Michael (20)
Virgilio, Anthony A. (7)
Visceglia, Frank R. (16)
Visconti, Joseph A. (9)
Vita, Frank J. (2)
Vitale, Dominic V. (20)
Viteri, Luis E. (3)
Viti, Henry A. (9)
Vitolo, Ralph E. (20)
Vogel, H. Austin (20)
Volpe, Donald J. (1)
Vol-Tretter, Marta (11)
von Deilen, Henry O. (14)
Von Hofe, Frederick H. (7)
Voorhees, Florence E. (7)
Voorhies, William S., Jr. (14)
Voorhis, Charles F. (3)
Vosburgh, Fred (16)
Voss, J. Landon (14)
Voss, John C. (3)
Vostrosablin, Nicholas A. (9)
Vreeland, Ralph J. (16)
Vroom, William L. (2)

W

ACTIVE MEMBERS

Wacker, William F. (20)
Wade, Francis A. (14)
Wade, Simon F. (20)
Wagner, J. George (3)
Wagner, John (7)
Wagner, Otto (20)
Wagner, Richard (20)
Wainright, Melvin A. R. (13)
Wakeley, William E. (7)
Waldron, Edward L. (11)
Waldron, Robert E. (7)
Walkenberg, Michael (7)
Walker, Ada H. (6)
Walker, Harold G. (16)
Walker, H. Burton (6)
Walker, Levi M. (1)
Walker, Robert B. (12)
Wallace, Marc J. (16)
Wallach, Bernard (18)
Wallack, Charles A. (7)
Wallack, Eli A. (9)
Walsh, Charles R. (7)
Walsh, Ronald J. (20)
Walsh, Thomas J. (11)
Walsh, Thomas J. (20)
Walters, George M. (12)
Walton, Gordon G. (16)
Walton, Ralph W. (7)
Wambsganss, Magdalena (7)
Wandall, Frederick G. (8)
Wangner, William F. (7)
Wantoch, Joseph (12)
Warburton, Jack C. (16)
Ward, Albert H. (16)
Ward, Albert J. (14)
Ward, Elisabeth B. (7)
Ward, Gertrude P. (7)
Ward, Leo J. (20)
Ward, Mary (2)
Ward, William R. (7)
Ward, William R., Jr. (7)
Ware, Carl N. (6)
Warne, Merna M. (14)
Warner, Halsey F. (7)
Warner, William H. A. (7)
Warren, Charles B. (2)
Warren, David E. (16)
Warren, Earl L. (16)
Warren, Jacob (16)
Warter, Peter J. (11)
Warwick, Ralph A. (4)
Washington, William H. (7)
Wassing, Hans (16)
Waterman, Samuel M. (7)
Waters, Charles H. (11)
Waters, Edward G. (9)
Watkins, George R. (4)
Watman, Anthony J. (9)
Watov, Samuel E. (11)
Watson, Frederick S. (11)
Watts, Wilbur (11)
Waugh, Bascom S. (4)
Way, Clarence W. (5)
Wayman, Bernard R. (11)
Webb, Eleanor A. (20)
Webb, Wilson D. (2)
Weber, Francis C. (7)
Weber, John F. (12)
Weber, Laura E. (9)

Weber, Walter D. (9)
Weeks, Belford A. (1)
Weeks, Norman E. (7)
Weems, Don B. (8)
Wegryn, Louis S. (20)
Weigel, Edgar W. (20)
Weigel, Elmer P. (20)
Weigele, Carl E. (9)
Weigert, Wolfgang U. (4)
Weimann, Max L. (4)
Weiner, Henry T. (12)
Weiner, Samuel E. (1)
Weinert, Henry V. (16)
Weinmann, Max H. (7)
Weinstein, Francis S. (7)
Weinstein, Leopold (7)
Weinstein, Morris W. (7)
Weinstein, Robert A. (19)
Weinstock, Michael B. (7)
Weintraub, William L. (16)
Weiser, Edward H. (19)
Weisman, Stephen L. (16)
Weiss, Abram (9)
Weiss, Herman (14)
Weiss, Louis (7)
Weiss, Morris J. (9)
Weiss, Mortimer H. (7)
Weiss, Selma (7)
Weissberg, William W. (20)
Weissman, Meyer T. (20)
Weitz, Paul (18)
Welkind, Allen A. (7)
Weller, Arthur (7)
Wells, William C. V. (3)
Weltchek, Herbert (20)
Wentzell, J. Earl (8)
Wesson, Harrison R. (7)
West, David H. (4)
West, Edgar L. (11)
West, Guernsey F. (21)
Westerhoff, Peter D. (16)
Western, Frederic B. (20)
Westney, F. Rolfe (1)
Weston, Clifford G. (7)
Wetterberg, Louis F. (12)
Whaland, Berta (6)
Whalen, Edward C. (4)
Wheatland, Marcus F., Jr. (4)
Wheeler, James A. V. (9)
Wheeler, William K. (7)
Whelan, Edward P. (7)
Whims, Clarence B. (1)
Whitaker, Henry J. (8)
White, Frank S. (2)
White, Harry J. (12)
White, R. Rostin (1)
White, Richard E. (16)
White, Robert R. (7)
White, Thomas J. (9)
Whiticar, John H. (5)
Whitken, Albert I. (20)
Whitman, Lloyd B. (2)
Wiant, Herman E. (4)
Wichman, Heins (9)
Wiener, David (7)
Wiesenfeld, Benjamin (12)
Wiesler, Howard M. (11)
Wiggins, Ulysses S. (4)
Wikoff, John L. (11)
Wilbur, Franklin L. (13)
Wilcox, Frank A. (9)
Wilentz, William C. (12)
Wilkins, Stanley O. (13)
Willan, Edward H. (7)
Willey, F. Parker (7)
Willey, Harry S., Jr. (13)
Williams, David P. (14)
Williams, Edith B. (2)
Williams, Frank A. (20)
Williams, Harry D. (11)
Williams, Hiram (16)
Williams, John J. (7)
Williams, Leonard D. (20)
Williams, Louis E. (14)
Williams, Manley C. (20)
Williams, Raymond A. (1)
Williams, William C. (2)
Willis, Benedict P. (2)
Willner, Irving (7)
Willner, Philip (7)
Willson, James H. (7)
Wilner, Arthur S. (11)
Wilner, Irving (11)
Wilson, Charles W. (6)
Wilson, Harrison B. (2)
Wilson, Herbert H. (6)
Wilson, John H., Jr. (7)
Wilson, Lawrence A. (1)
Wilson, Lester R. (4)
Wilson, Robert B. (13)
Winn, Samuel L. (1)
Winslow, John H. (6)
Winter, Carl M. (4)
Winter, Egon W. (7)
Winter, Gladys C. (2)
Winters, Walter M. (16)
Wishnack, Meyer (16)
Witkoff, Ben. (2)
Witmer, John D. (12)
Witte, C. Norman (15)
Wittenborn, William F. J. (11)
Woelfle, Henry E. (9)
Wolbert, Charles M. (9)
Wolf, Erich (16)
Wolf, Frank A. (21)
Wolf, Israel J. (16)
Wolf, Raymond E. (7)
Wolfe, Edward E. (2)
Wolfe, Jacob S. (7)
Wolfe, William W. (7)
Wolff, Herbert M. (11)
Wolff, Jerome M. (20)
Wolfram, Julius (18)
Wolfsie, Jacob H. (18)
Wolfson, Harry (16)
Wolgin, Philip L. (20)
Wolowitz, Harry B. (2)
Woltz, Sidney (9)
Wood, E. LeRoy (7)
Woodman, Charles B. (14)
Woodruff, Dare (6)
Woodruff, Ralph G. (13)
Woody, McIver (20)
Woolf, Bernhardt H. (7)
Worcester, George F. (2)
Work, John L. (7)
Woronoff, Murray (13)
Wort, Frederick J. (7)
Worthington, Joseph A. (13)
Wrensch, Alexander E. (7)
Wright, Herman W. (8)
Wright, Ralph S. (4)
Wright, Robert E. (7)
Wroblewski, Benjamin M. (4)
Wry, Dean A. (16)
Wry, Orlin V. (2)
Wuerthele, Virginia E. (7)
Wuester, William O. (20)
Wujciak, Henry J. (7)
Wurts, Margaret M. (7)
Wurzel, Milton (7)
Wyatt, Joseph H. (7)
Wyker, Arthur W. (7)
Wyman, Edward H. (3)
Wynder, Alfred (7)

ASSOCIATE MEMBERS

Wagener, William L. (1)
Walker, Otto (12)
Wiesenfeld, Paul (12)
Willner, Albert (7)

Y

ACTIVE MEMBERS

Yablonsky, Max (7)
Yachnin, Samuel C. (16)
Yadkowsky, Emanuel (7)
Yaeger, Leslie A. (11)
Yager, J. Allen (16)
Yaguda, Asher (7)
Yankowiez, Michael (7)
Yarnell, Helen (20)
Yates, Glen L. (7)
Yates, John S. (16)
Yeaton, William L., Jr. (9)
Yeaw, Ralph C. (16)
Yelin, Gabriel (7)
Yellin, Charles H. (20)
Yingling, Paul L. (5)
Yolken, Harry (16)
Yontef, Reuben (9)
York, James L. (2)
York, Wilbur H. (11)
Yorke, Edward T. (20)
Yoskalka, Jack S. (7)
Young, Franklin C. (20)
Young, George J. (14)
Young, I. Henry (7)

Young, James L. (18)
Young, John H. (7)
Young, Ralph A. (20)
Yuckman, Robert O. (20)
Yuckman, William (20)
Yunck, William, Jr. (9)
Yunck, William P., Jr. (9)

ASSOCIATE MEMBER

Yoskowitz, Benjamin (16)

Z

ACTIVE MEMBERS

Zacchino, Arnold A. (2)
Zacher, Andrew A. (7)
Zager, Saul (7)
Zalewski, Irene J. (16)
Zapf, Reville D. (8)
Zappala, John (17)
Zehnder, A. Charles (7)
Zeitlin, Herman H. (20)
Ziccardi, Anthony V. (3)
Zick, Clara U. (16)
Zimmer, William (7)
Zimmerman, Coler (7)
Zimmerman, Robert F. (14)
Zimskind, Joshua N. (11)
Zingales, Joseph A. (20)
Zingali, John A. (7)
Zitani, Alfred M. (9)
Zuck, Arthur C. (21)
Zuckerman, David E. (16)
Zvaifler, Nathan (7)
Zweibel, Leonard (7)
Zweigel, Isidore (7)
Zybulewski, Edmund A. (7)

ASSOCIATE MEMBER

Zigarelli, Joseph F. (16)

MEMBERSHIP OF COUNTY MEDICAL SOCIETIES

Comprising

THE MEDICAL SOCIETY OF NEW JERSEY

ON MARCH 1, 1946

Bold face type indicates members in service

ATLANTIC COUNTY (1)

Society organized June 7, 1880. Meets second Friday evening monthly, except in June, July and August. Annual Meeting in May.

ACTIVE MEMBERS

Allman, David B., 104 St. Charles pl., Atlantic City
Andrews, Clarence L., 1616 Pacific av., Atlantic City
Axilrod, Maurice H., 2620 Pacific av., Atlantic City
Barbash, Samuel, 1902 Pacific av., Atlantic City
Bartlett, Clara K., 4301 Atlantic av., Atlantic City
Bassett, Norman H., 1616 Pacific av., Atlantic City
Beir, Ily R., 3900 Atlantic av., Atlantic City
Bew, Richard C., Navy
Bradley, Robert A., 1616 Pacific av., Atlantic City
Brown, J. Carlisle, 101 S. Indiana av., Atlantic City
Carrington, William J., Army
Chalfant, W. Paxson, Jr., Army
Charlton, C. Coulter, 124 S. Illinois av., Atlantic City
Clark, S. Worth, 152 S. No. Carolina av., AtlanticC'y
Cleary, Joseph P., Minotola
Corson, Filbert R., 101 S. Indiana av., Atlantic City
Crane, Bernard, 306 Pacific av., Atlantic City
Dalton, S. Eugene, 101 S. Surrey av., Ventnor
Davidson, Harold S., 117 S. Illinois av., Atlantic City
deHellebranth, Roland T., 104 S. Fr'nkf't av.,Ventn'r
DiNicolantonio, Vincent J., Army
Diskan, Samuel M., Army
Donnelly, William A., Navy
Durham, Robert B., Navy
Durham, Royal E., 100 S. New Haven av., Ventnor
Dyer, Edward H., 102 S. Victoria av., Ventnor
Eckert, Walter L., 809 Stenton pl., Ocean City
Elliott, Frazier J., Army
Erber, Leonard B., 2 N. Dover av., Atlantic City
Ernst, Philip A., 16 E. Main st., Mays Landing
Esposito, Antonio L., 31 12th st., Hammonton
Ewens, Arthur E., 3600 Pacific av., Atlantic City
Feinstein, Louis, 410 Pacific av., Atlantic City
Fish, Clyde M., 7 W. Washington av., Pleasantville
Fowler, Richard M., Jr., 112 N. Indiana av., Atl.City
Fox, Wm. W., 101 S. Indiana av., Atlantic City
Frank, Myrtile, 227 Philadelphia av., Egg Harbor
Frank, Perry, 227 Philadelphia av., Egg Harbor
Goldstein, Samuel, 34 E. Main st., Mays Landing
Gordon, Benjamin L., 1616 Pacific av., Atlantic City
Gordon, Maurice B., 6917 Atlantic av., Ventnor
Gorson, Samuel F., 2005 Pacific av., Atlantic City
Gottlieb, Morris, 9 S. Swarthmore av., Atlantic City
Grier, Robt. M., 50 E. Washington av., Pleasantville
Gross, Max, 7401 Atlantic av., Margate City
Gruhler, Jean A., 14 S. Avalon av., Ventnor
Guion, Edward, Atlantic Co. Hosp., Northfield
Halpern, Samuel, Army
Harley, Halvor L., 101 S. Indiana av., Atlantic City
Harris, William O., 32 N. New Jersey av., Atl. City
Hersohn, William W., Army
Hess, L. Elmore, 19 E. Bolton av., Absecon
Hoffman, Harry S., 3302 Pacific av., Atlantic City
Holmes, H. David, 15 N. Indiana av., Atlantic City
Holoman, M. Browne, 1 N. Haverford av., Margate
Holt, Edward Z., 4100 Atlantic av., Atlantic City
Hudson, Howard S., Army
Hyman, Chas., 2807 Pacific av., Atlantic City
Infield, Gerald L., Army
Irvin, John S., 1910 Pacific av., Atlantic City
Jacobson, J. Joseph, 1616 Pacific av., Atlantic City
Johnson, V. Earl, 101 S. Indiana av., Atlantic City
Kahn, Leo, 32 States av., Atlantic City
Kaighn, Chas. B., 101 S. Indiana av., Atlantic City
Kline, Herman, 2643 Pacific av., Atlantic City
Konzelmann, Frank W., 304 S. Shore rd., Absecon
Krechmer, Abraham, 400 Pacific av., Atlantic City
Lawther, Boyd M., 1401 Shore rd., Northfield
Leonard, Isaac E., 2842 Atlantic av., Atlantic City
Leonard, Isaac E., Jr., 2842 Atlantic av., AtlanticC'y
Magill, Marcus, 4116 Ventnor av., Atlantic City
Major, Morton M., Army
Marshall, H. Donald, 707 N. Indiana av., AtlanticC'y
Marvel, Peter H., 2216 Shore rd., Northfield
Mason, James H., 1616 Pacific av., Atlantic City
McGeehan, Stanley M., 6505 Atlantic av., Ventnor
Merendino, Anthony G., 2720 Pacific av., AtlanticC'y
MeVay, James C. F., 2907 Pacific av., Atlantic City
Milano, Cesare A., 1 S. Brighton av., Atlantic City
Mishler, Jay E., Army
Molitch, Matthew, Army
Murray, Clifford K., Navy
Nickman, E. Harrison, Army
Oesterlin, Ernst J., Army
Pennington, John, 101 S. Indiana av., Atlantic City
Perez, John F., 3403 Pacific av., Atlantic City
Petinga, Thomas J., 114 S. Illinois av., Atlantic City
Pilkington, Albert, 117 S. Virginia av., Atlantic City
Poland, Geo. A., 206 E. Verona av., Pleasantville
Quinn, Norman J., 3303 Pacific av., Atlantic City
Read, Hilton S., 5407 Atlantic av., Ventnor
Repici, Anthony J.,55Ev'rgr'n lane.NewHydePk.,N.Y.
Reyner, Daniel C., 2703 Pacific av., Atlantic City
Rieck, Allan, Army
Rise, Wilson S., Army
Rodi, Louis M., 412 Bellevue av., Hammonton
Roop, William O., 101 S. Indiana av., Atlantic City
Rosenberg, Louis, 10 S. Vassar sq., Atlantic City
Rosenblatt, Sidney, 1904 Pacific av., Atlantic City
Rubba, Russell R., Army
Salasin, Samuel L., 511 Pacific av., Atlantic City
Saseen, Charles A., 60 S. Delancey pl., Atlantic City
Scanlan, D. Ward, 15 S. Illinois av., Atlantic City
Schwarzkopf, George C., 2901 Pacific av., AtlanticC'y
Schwinn, Chas., 7600 Winchester av., Margate City
Shavelson, Irving C., 1616 Pacific av., Atlantic City

Shenfeld, Isaac, 4806 Atlantic av., Ventnor
Shivers, Chas. H. deT., 121 S. Illinois av., Atl. City
Shuster, Samuel A., 405 Pacific av., Atlantic City
Silvers, Homer I., 16 S. Suffolk av., Ventnor
Sinkinson, Chas. D., Jr., 1616 Pacific av., AtlanticC'y
Smith, Andrew M., 344 Philadelphia av., Egg Harbor
Stamps, G. Ruffin, 300 E. Verona av., Pleasantville
Stewart, Sloan G., Army
Stewart, Walter B., 8 N. Tallahassee av., Atl. City
Subin, Harry, Army
Surran, Carl A., 1616 Pacific av., Atlantic City
Timberlake, Baxter H., 5414 Ventnor av., Atl. City
Uzzell, Edward F., 2703 Pacific av., Atlantic City
Vandenberg, Werner, 4116 Ventnor av., Ventnor
Volpe, Donald J., Navy
Walker, Levi M., 5407 Atlantic av., Ventnor
Weeks, Belford A., Army
Weiner, Samuel E., 904 Pacific av., Atlantic City
Westney, F. Rolfe, 1920 Pacific av., Atlantic City
Whims, Clarence B., Army
White, R. Rostin, 644 Shore rd., Somers Point
Williams, Raymond A., 7207 Atlantic av., Ventnor
Wilson, Lawrence A., 114 N. Shore rd., Absecon
Winn, Samuel L., 1616 Pacific av., Atlantic City

Number of Active Members and basis of representation, 130.

ASSOCIATE MEMBERS

Cutler, Milton, 554 Bellevue av., Hammonton
Dein, Harry, 1616 Pacific av., Atlantic City
Lippman, Nathan L., 306 Pacific av., Atlantic City
McCracken, Josiah C., Jr., 16 S. Suffolk av., Ventnor
McGahn, Joseph, Army
Morrow, Charles S., 101 S. Indiana av., Atlantic City
Naame, John M., 19 N. Dorset av., Ventnor
Reinhard, Louis, 2627 Pacific av., Atlantic City
Salasin, Robert G., Atlantic City Hosp., AtlanticC'y
Targan, Nathan, 4116 Ventnor av., Atlantic City
Wagner, William L., Army

COURTESY MEMBERS

Rechtman, A. M., Philadelphia, Pa.
Starkes, Carlton C., Linwood

HONORARY MEMBERS

Marcus, Joseph H., New York City
Martin, William, Haddonfield

BERGEN COUNTY (2)

Society organized February 28, 1854 . Meets on second Tuesday of each month, except July and August. Annual Meeting in May.

ACTIVE MEMBERS

Agayoff, John D., 127 S. Washington av., Bergenfield
Alexander, Samuel, 12 S. Main st., Park Ridge
Alexander, Stewart F., 12 S. Main st., Park Ridge
Anderson, Ethelyn J. C., 195 Euclid av., Ridgef'dPk.
Anderson, Reuben M., 15 Anderson st., Hackensack
Angelillis, Paul, Army
Angioletti, Louis V., 501 W. 178th st., N. Y. C.
Appold, George D., 60 E. Church st., Bergenfield
Baketel, H. Sheridan, 155 Van Wagenen av., Jer. C'y
Baldwin, John F., Army
Balze, Henry R., 147 Christie st., Leonia
Banta, Raymond E., 201 E. Ridgew'd av., Ridgewood
Barbash, Roslyn H. W., 835 Red rd., Teaneck
Barlow, G. Barton, 157 Engle st., Englewood
Barnes, William J., 155 Engle st., Englewood
Baron, Herbert A., 150 Terrace av., Hasbrook Hts.
Basralian, Joseph B., 333 W'sh'gt'n pl., Hasbr'k Hts.
Beres, Albert J., 492 Wood-Ridge av., Wood-Ridge
Berke, Raynold N., 430 Union st., Hackensack
Bernard, Richard C., Army
Beyer, William, 612 Undercliff av., Edgewater
Black, LeRoy W., 33 W. Passaic av., Rutherford
Blauvelt-Welles, Grace B., 76 Heights rd., Ridgew'd
Bleasby, Charles B., 136 Passaic st., Garfield
Blenkle, Victor A., Army
Bono, Joseph J., 647 Anderson av., Cliffside Park
Bookstaver, Barnet S., 241 Cedar lane, Teaneck
Bosch, Taeke, 290 E. Franklin Turnpike, Hohokus
Branon, Mark E., 16 W. Passaic av., Rutherford
Braun, Joseph C., 531 Broad av., Palisades Park
Bregman, Alexander, 2 Dempsey av., Edgewater
Brennan, Alfred T. V., Jr., 275 Engle st., Englewood
Brown, John L., 1019 Cumbermede rd., Palisade
Brown, Leonard, 190 Park st., Ridgefield Park
Brozyna, Micczyslaw, Army
Buckley, Paul J., 159 Palisade av., Bogota
Bump, Samuel C., 65 N. Maple av., Ridgewood
Burnham, Lyman, 229 Engle st., Englewood
Burns, Geoffrey C. H., County rd., Demarest
Busicco, Philip S., 131 Liberty rd., Englewood
Calabrese, D. John, 114 Rochelle av., Rochelle Park
Campbell, James M., 101 S. Central av., Ramsey
Candio, Vincent P., 347 Ridgewood rd., Lyndhurst
Carbone, Ralph, 2431 Lemoine av., Coytesville
Carroll, Thomas R., 754 Anderson st., Grantwood
Cartnick, Louis C., 228 Hillcrest av., Wood-Ridge
Caruso, Paul F., Army
Casciano, Adolph D., Army
Chase, Kalman, Jr., 80 Sheridan av., Hohokus
Claric, D'Arcy C., Army
Clark, Margaret A., Glen rd., Woodcliffe Lake
Clarke, Edward W., 435 Warwick av., W. Englew'd
Cloud, Albert W., 139 Hugenot av., Englewood
Connor, Clarence A., 1586 Center av., Fort Lee
Coppoletta, Joseph M., 452 Palisade av., Cliffside Pk.
Corn, David, 119 Park st., Ridgefield Park
Conghlin, Joseph J., Army
Crandall, John K., 200 Main st., Fort Lee
Cropsey, Charles D., 168 Chestnut st., Rutherford
Curtis, Donald A., 241 Union st., Hackensack
D'Agostin, Henry, 243 Fulton ter., Cliffside Park
Daly, John F., 877 Queen Anne rd., Teaneck
D'Amato, Charles R., 324 Hoboken rd., E. Rutherf'd
DeBiaso, Cornelius V., 9 W. Park pl., Rutherford
DeCecio, Thomas, 691 Palisade av., Cliffside Park
Demarest, J. Willis, 124 Elm av., Hackensack

DeSanto, A. M., Summit av. & Essex st., Hackens'k
Deuell, William D., 190 Elm av., Hackensack
Dezer, Charles N., Jr., 210 Main st., Hackensack
Dickson, John D., 202 Larch av., Bogota
Dilger, Frederick G., 210 Main st., Hackensack
Doyle, George F., Army
Duffy, Joseph F., 358 Kinderkamack rd., Westwood
Duisberg, Richard E. H., 22 Ward st., Hackensack
Edgerly, Sherburn E., Navy
Edwards, J. Bennett, 144 Woodridge pl., Leonia
Ehrlich-Morrow, Laura E., 42 Ridge rd., Rutherford
Ellmers, Basil J., 304 Milford av., New Milford
Essertier, Edward P., 275 State st., Hackensack
Essertier, Harland C., 263 Franklin av., Ridgewood
Evans, J. Lawrence, Jr., 254 ChristieHgts. st.,Leonia
Farmer, Vincent, 430 Union st., Hackensack
Farr, Walter J., 288 Griggs av., Teaneck
Fechner, Fred J., 846 Garrison av., Teaneck
Fechner, Herta, 846 Garrison av., Teaneck
Fermaglich, Harry B., 881 Garrison av., Teaneck
Ferrari, Andrew F., 196 Main st., E. Rutherford
Fietti, Vincent G., Army
Finke, George W., 237 State st., Hackensack
Finke, John H. D., 19 Hudson st., Hackensack
Fitzhugh, William F., 190 Euclid av., RidgefieldPark
Fitzpatrick, Leo J., Army
Fliegel, William M., 85 W. Passaic st., Maywood
Forte, F. Chester, 111 State st., Hackensack
Freeland, Frank, 281 State st., Hackensack
Friedman, Abraham I., 280 State st., Hackensack
Gatti, Joseph D., 92 E. Hunter av., Maywood
Gershman, Joseph G., 185 E. Madison av., Dumont
Gilady, Raphael, 205 Union st., Hackensack
Giordano, William C., 855 Broad av., Ridgefield
Gitterman, David A., 519 Engle st., Englewood
Gladstone, Albert L., 886Kinderkam'k rd.,RiverEdge
Goldberg, David, Westwood av., Westwood
Goldfarb, Abraham, Navy
Gould, Werner, 219 Passaic st., Hackensack
Greenfield, Arthur W., 50 Anderson st., Hackensack
Greenfield, William J., 50 Anderson st., Hackensack
Grimes, Robert R., 480 Sagamore av., Teaneck
Groff, Parker A., 159 Washington av., Little Ferry
Grueninger, Edward F., Army
Guidice, Vincent W., Harrison av., Waldwick
Hagovsky, Albert J., 301 Hackensack st., Carlstadt
Hallett, Frederick S., 200 Passaic st., Hackensack
Halpern, Herman, 143 Engle st., Englewood
Halpern, Jesse O., Army
Harryman, William K., 271 Union st., Hackensack
Hawes, Vernon L., Army
Helff, Joseph R., 1367 Teaneck rd., W. Englewood
Heller, George, 460 Engle st., Englewood
Hensle, Otto S., 210 Main st., Hackensack
Hillsman, R. Bryan, 268 Vandelinda av., Teaneck
Hirsch, John J., Army
Hitzemann, Louis A., 30 E. Passaic st., Maywood
Hoops, Harold J., 25 Woodland Park drive, Tenafly
Horowitz, Herman J., 872 Broad av., Morsemere
Hull, Donald B., 88 W. Ridgewood av., Ridgewood
Irwin, John H., 51 Tenafly rd., Englewood
Jacobitti, Edmund E., 491 Maywood av., Maywood
Jaslow, Seymour P., Wyckoff
Jenkins, Alvah R., 40 Armory st., Englewood
Johnson, G. Leonard, 390 Booth av., Englewood
Johnston, Rufus O., Parkside rd., Harrington Park
Johnston, Sidney F., 365 Rochelle av., Rochelle Park
Jordan, Walter L., 145 Engle st., Englewood
Jukofsky, Isidore D., 335 Main st., Ridgef'd Park
Kakascik, Emil J., Navy
Kaplan, Isaac, 901 Garrison av., Teaneck
Kastler, Franz, 54 Ames av., Rutherford
Keir, Floyd E., 308 Engle st., Englewood
Kilts, Winfield S., 966 Garrison av., Teaneck
King, Chester A., 412 Kinderkamack rd., Oradell
Kingma, John G., Goffle Hill rd., Midland Park
Kingslow, George L., 346 1st st., Hackensack
Kissinger, Donald J., Army
Klosterman, Julius A., Army
Knapp, Richard E., 25 Hudson st., Hackensack
Knight, William T., 515 Oradell av., Oradell
Knowles, George M., Army
Knox, Charles A., 138 Bergen av., Ridgefield Park
Knox, Harriet L., 390 Union st., Hackensack
Kraissl, Cornelius J., 230 Kinderk'm'k rd.,N.H'ck'n'k
La Barba, Peter J., Navy
Lamberto, Vito A., 422 Stuyvesant av., Lyndhurst
Latona, Joseph A., 78 Main st., Lodi
Legato, Samuel F., Army
Lemmerz, Willard H., 184 Hackens'k st.,Wood-Ridge
Lesko, Stephen W., 234 Mt. Pl'sant av.,E.Rutherford
Levitas, Irving M., Kinderkamack rd., Westwood
Levy, Jack D., 191 Union st., Hackensack
Lewis, Alice B., E. Saddle River rd., Saddle River
Liddy, Frank J., Mahwah
Littwin, Charles, 950 Queen Anne rd., Teaneck
Liva, Arcangelo, 100 Prospect av., Hackensack
Liva, G. Albin, Madison av., Wyckoff
Liva, Paul F., 280 Stuyvesant av., Lyndhurst
Loman, Samuel G., 130 Magnolia av., Cresskill
Lombardi, Frank L., Navy
Lord, C. Donald, 496 S. Maple av., Glen Rock
Luria, Sanford A., 249 Queen Anne rd., Bogota
Lynch, Maurice M., 396 Union st., Hackensack
Lyons, Romola L. K., 171 Meadowbr'k rd., Englew'd
Macaulay, Francis A., 819 Elm av., Teaneck
MacKellar, James M., 26 E. Clinton av., Tenafly
MacLaren, Philip J., Navy
Maddren, Russell F., 372 Union st., Hackensack
Mader, A. Ivan, Jr., 430 Union st., Hackensack
Mahoney, Thomas H., 321 Ridge rd., Rutherford
Mancene, Edward M., Army
Mark, Harold I., 1022 Garrison av., Teaneck
Markley, Luther A., Holy Name Hosp., Teaneck
Marx, Frederick J., 539 Kinderkam'k rd., River Edge
McCormack, Frank C., 95 Tenafly rd., Englewood
McFeely, Percy R., 242 Palisade av., Bogota
McIlveen, Marion, 260 Godwin av., Ridgewood
McLane, A. Donald, Army
McLeod, Harry J., 71 Forest rd., Tenafly
Mears, William G., 216 Hillside av., Leonia
Megibow, Harold J., Main st., Ramsey
Metz, Henry, 384 Fairmount av., Jersey City
Meyer, Howard M., 400 Maple Hill dr., Hackensack
Miller, Herbert G., Army
Modrys, Walter F., Army
Mores, Herbert R., address unknown
Morrow, Joseph R., 45 N. Broad st., Ridgewood
Moss, Jack W., Wyckoff
Muller, Frederick L., 413 Third st., Carlstadt
Mulligan, Luke A., 230 Central av., Leonia
Myers, Norman V., 41 Magnolia av., Tenafly
Neary, Edward R., Army
Netz, Lester W., 414 Main st., Hackensack
Neville, Robert J., 547 Main st., Hackensack
Nichols, Frank I., 52 Euclid av., Hackensack
Nicol, Lorenz C., 360 Larch av., Bogota
Olpp, John L., 100 E. Palisade av., Englewood
Olson, Vendela E., 100 Prospect av., Hackensack
Oren, Hyman, 24 Park av., Park Ridge
Padden, Aloysius F., 15 Anderson st., Hackensack
Pagano, Peter, 324 Franklin av., Ridgewood
Pallen, Conde deS., Army
Patti, Frank A., 241 Broad av., Leonia
Pedevill, Joseph R., 232 Highland av., Palisades P'k
Pellegrini, Vincent J., 345 Rochelle av., Rochelle P'k
Perham, Roy G., 248 Blvd., Hasbrouck Heights
Pettit, Harry H., 138 Franklin av., Ridgewood

Phillips, Walter, 109 E. Palisade av., Englewood
Pierce, Henry A., Army
Pindar, Arthur W., 627 Queen Anne rd., Teaneck
Pindar, Irene D., 627 Queen Anne rd., Teaneck
Pingitore, Eufelia, 30 Martin ter., Hackensack
Pizzi, Peter J., Army
Placa, James A., 200 Oak st., Ridgewood
Policastro, Nelson C., 378 Union st., Hackensack
Prather, Charles G., Army
Prather, John W., 155 Washington av., Dumont
Protzman, Thomas B., 408 Conrad rd., Englewood
Prout, William B., 88 W. Forrest av., W. Englewood
Rader-Hoheb, Katherine, 5 Lincoln av., Rutherford
Rappaport, Doris I., 1363 Sussex rd., W. Englewood
Ravits, Everett C., Army
Re, Natale M., 1003 Dearborn rd., Palisade
Reich, Samuel B., 286 Union st., Hackensack
Reid, Erwin W., 125 Marsellus pl., Garfield
Reinhold, H. E., 441 W. Englewood av., W. Englew'd
Richards, Ernest W., 374 DeWolf pl., Hackensack
Richardson, Charles A., Main st., Closter
Ringe, Charles L., Jr., Army
Ringewald, Robert H., 284 Broad av., Leonia
Roberts, Charles D., 71 Chestnut st., Englewood
Romano, Anthony M., 164 Maple st., Englewood
Ross, Selig J., 2143 77th av., Jackson Hts., N. Y.
Rowe, Joseph A., 174 S. Maple av., Ridgewood
Rowohlt, George O., 150 E. Madison av., Dumont
Roylance, F. Dean, Jr., Army
Rube, Joseph A., Army
Rucker, William C 408 Main st., Hackensack
Ryley, Harold W., Lincoln pl., E. Rutherford
Salmeri, Edward ».., Army
Salva, Edo J., 17 W. Central Blvd., Palisades Park
Sandler, Moses, 2013 Center av., Fort Lee
Sandler, Samuel A., 282 State st., Hackensack
Sarajian, Aram M., 131 Ayers ct., W. Englewood
Sarla, Michael, 55 Hudson st., Hackensack
Scerbo, Ernest, 1-09 34th st., Warren Point
Schaberg, Frank J., Army
Schiro, S. Robert, 73 Main st., Lodi
Schmidt, Walter W., 386 Palisade av., Cliffside Park
Schretzmann, Rudolph C., 60 D'nalds'n av., R'therf'd
Schultz, Irving A., 31-11 Broadway, Warren Point
Scillieri, John, 541 E. 21st st., Paterson
Scullion, Arthur A., 460 Anderson av., Cliffside Park
Sealey, Henry J., 79 Washington av., Dumont
Segard, Christian P., 204 Glenwood av., Leonia
Seiler, Benjamin, 580 Palisade av., Cliffside Park
Severud, Olaf J., Navy
Sexton, Edward V., 936 Queen Anne rd., Teaneck
Seymour, Edward T., 55 Hillside av., Tenafly
Singer, Marie J., 139 E. Madison av., Dumont
Skvarla, John A., 17 Koster st., Wallington
Smaine, Enrique del C., Army
Smith, Bryan A., 10 N. Monroe st., Ridgewood
Smith, Nehemiah E., 33½ Humphrey st., Englewood
Snedecor, Spencer T., 200 Passaic st., Hackensack
Solworth, Lee, Army
Somers, Williard H., 157 Engle st., Englewood
Sosnow, Louis M., 51 Central av., Hillsdale
Spicola, Louis A., Army
Spiegelglass, Abraham B., 417 Main st., Hackensack
Spranz, William S., 546 Oradell av., Oradell
Stassi, Anthony, 481 Passaic av., Lodi
Sullivan, John B., Army
Taylor, Harold W., 247 Mountain rd., Englewood
Tennis, Edgar M., 375 Engle st., Englewood
terKuile, Reinold W., 88 W. Ridgew'd av.,Ridgewood
Tether, Russell K., Main st., Closter
Toal, Joseph, 803 Prospect av., Ridgefield
Tomlins, Francis I., 325 Pearsall av., Ridgewood
Turner, Isabel B., 141 Sheffield av., Englewood
Twinem, Francis P., 450 Summit av., Hackensack
Tyson, Frances B., 101 Leonia av., Leonia
Utens, Max, Army
Vanderbeek, Stuart W., 143 Engle st., Englewood
Vandersluis, Harold H., 86 S. Main st., Park Ridge
Van Dyke, Joseph S., 42 Palisade Blvd., Palisades P'k
Vann, Dorothea D., 63 Spring lane, Englewood
Vann, Felix H., 179 Hillside av., Englewood
Van Riper, William D., 44 Tenafly rd., Englewood
Van Winkle, Charles I., 79 Ridge rd., Rutherford
Vilardo, Ross, 109 Marsellus pl., Garfield
Vita, Frank J., Army
Vroom, William L., 88 W. Ridgew'd av., Ridgewood
Ward, Mary, 30 Engle st., Tenafly
Warren, Charles B., 181 Prospect av., Bergenfield
Webb, Wilson D., 210 Main st., Hackensack
White, Frank S., Navy
Whitman, Lloyd B., 7 W. Clinton av., Bergenfield
Williams, Edith B., 70 Anderson st., Hackensack
Williams, William C., 9 Ridge rd., Rutherford
Willis, Benedict P., 185 Montross av., Rutherford
Wilson, Harrison B., 430 Union st., Hackensack
Winter, Gladys C., 805 Red rd., Teaneck
Witkoff, Ben., 215 Terrace av., Hasbrouck Heights
Wolfe, Edward E., Army
Wolowitz, Harry B., 20 Spring Valley av., Hackens'k
Worcester, George F., 220 Engle st., Englewood
Wry, Orlin V., 95 High st., E. Rutherford
York, James L., Army
Zacchino, Arnold A., Navy

Number of Active Members and basis of representation, 317.

ASSOCIATE MEMBERS

Audi, Eugene H., 46 Maple st., Glen Rock
Bassett, Samuel, 355 Washington av., Dumont
Bayer, Eric C., 307 W. Madison av., Ridgefield
Calabrese, Dino, 201 Main st., Fort Lee
Davis, Harold, 170 S. Washington av., Bergenfield
DeLuca, Louis, 323 E. Ridgewood av., Ridgewood
Dul, Emil J., 154 Plauderville av., Garfield
Lowe, Louise, 125 Lawrence av., Hasbrouck Heights
Magee, William P., 1009 Abbott Blvd., Palisade
McWhorter, John E., 115 Grand av., Englewood
Pramuk, Clarence, 764 Cedar lane, Teaneck
Sullivan, John A., 764 Queen Anne rd., Teaneck

COURTESY MEMBERS

Franklin, Sidney I., Newberry, Michigan
Hambright, Arthur M., Ramsey
Opitz, Russell B., Palisade
Pfeiffer, Alfred G., Paramus
Salter, Kent, Paterson

HONORARY MEMBERS

Burbank, Hugh E., Lyndhurst
Clock, Ralph O., Scarsdale, N. Y.
Proctor, James W., Tenafly
Tidwell, George W., Rutherford

BURLINGTON COUNTY (3)

Society organized May 19, 1829. Regular meetings on second Thursday evening of each month except June, July and August, at Riverton Country Club, Riverton. Annual Meeting in May.

ACTIVE MEMBERS

Anderson, Richard D., Navy
Atkinson, James Q., 63 Mill st., Vincentown
Barton, Amy S., 509 Chester av., Moorestown
Betts, R. Winfield, 22 N. Main st., Medford
Bray, William E., 41 Elizabeth st., Pemberton
Busansky, Samuel T., Circle dr., Browns Mills
Clement, John B., Army
Curtis, Howard C., 224 E. Main st., Moorestown
Darlington, Emlen P., New Lisbon
Davis, E. Vernon, Army
Davis, Jacob M., 1400 High st., Burlington
Dickson, T. Bruce, 408 Main st., Riverton
Downs, Roscius I., 430 Cooper st., Woodbury
Fahrenbruch, Fred'k D., 101 Garden st., Mt. Holly
Fischbach, Adolph D., 108 Hanover st., Pemberton
Geary, Russell D., 337 Bridgeboro rd., Riverside
Gibson, Charles F., 131 E. Federal st., Burlington
Haines, Edgar J., 45 S. Main st., Medford
Haldeman, Robert E., 34 Garden st., Mt. Holly
Hale, Matthew J., 467 High st., Burlington
Hartman, Luther M., 111 E. Main st., Maple Shade
Hebble, Howard M., 129 Chester av., Moorestown
Hornberger, J. Howard, 4th & Main sts., Roebling
Hunter, Edward R., 321 Union av., Delanco
Imhoff, Robert E., 29 E. Main st., Moorestown
Kuder, Joseph M., 104 Garden st., Mt. Holly
Laudis, Harry P., Jr., Army
LeFavor, Dean H., 619 Morgan av., Palmyra
Longsdorf, Harold E., 200 Garden st., Mt. Holly
Love, Elizabeth F., 142 E. Oak av., Moorestown
Lucas, W. Fred, 23 W. Broad st., Burlington
Mark, Harry B., 600 Elm ter., Riverton
McDonnel, Gerald E., 470 High st., Mt. Holly
Mendenhall, Clinton D., 412 F'rnsw'th av.,Bordent'n
Metzer, Emma P. W., 430 Fairview st., Riverside
Metzer, Freeman W., 428 Fairview st., Riverside
Meyer, Eugene A., Army
Mills, Charles S., 106 Lippincott av., Riverton
Muldoon, Edward J., Navy
Munro, Charles A., Main st., Marlton
Newcomb, Marcus W., Browns Mills
Newmeyer, Joseph, 27th st. & Baird Blvd., Camden
Peacock, Arthur B., 201 E. Main st., Moorestown
Rachunis, Michael, 5th & Riverside avs., Roebling
Remer, Daniel F., 417 High st., Mt. Holly
Rodman, E. Warren, 612 Spruce st., Beverly
Sand, Abraham B., 207 E. Union st., Burlington
Schisler, Milton M., 2nd & Church sts., Florence
Scott, Parry M., 466 Cooper st., Beverly
Shapiro, Charles S., S. Forklanding rd., Maple Shade
Shipps, Hammell P., 739 Chestnut st., Delanco
Small, E. Lester, 30 Branch st., Medford
Sparks, Paul R., 102 W. Broad st., Burlington
Stokes, Joseph, 220 E. Main st., Moorestown
Stokes, S. Emlen, 129 Chester av., Moorestown
Strenski, John, 540 Bridgeboro st., Riverside
Summey, Thomas J., 800 Golf View rd., Moorestown
Thorne, Nathan, 119 Chester av., Moorestown
Tracy, George T., 222 Warren st., Beverly
Ulmer, D. H. B., 199 Chestnut st., Moorestown
Viteri, Luis E., 214 Main st., Mt. Holly
Voorhis, Charles F., 330 Morgan av., Palmyra
Voss, John C., 634 Thomas av., Riverton
Wagner, J. George, Riverbank, Delanco
Wells, William C. V., Navy
Wyman, Edward H., 100 E. Broad st., Burlington
Ziccardi, Anthony V., 210 W. Main st., Maple Shade

Number of Active Members and basis of representation, 67.

CAMDEN COUNTY (4)

Society organized August 14, 1846. Meets first Tuesday in each month, October to May, inclusive, with an outing in June. Annual Meeting in May.

ACTIVE MEMBERS

Anderson, Wm. M., 20 Kings H'way, W., Hadd'nf'd
Andrus, David L., 805 Cooper st., Camden
Angus, Leslie R., 437 Kings H'way, E., Haddonfield
Asbell, Nathan, 326 Cooper st., Camden
Assante, M. Hugo, Army
Athey, Kenneth L., 3616 Westfield av., Camden
Baker, Banks S., 618 Benson st., Camden
Baker, Maurice E., 1149 Kaighn av., Camden
Barb, Kirk B., 1303 Princess av., Camden
Barnshaw, Harold D., 406 Cooper st., Camden
Barroway, James N., Army
Becker, C. Frederick, 620 Benson st., Camden
Beideman, Casper M., 5 W. Maple av., Merchantville
Bentley, David F., Jr., 406 Cooper st., Camden
Betancourt, Raul R., Army
Bianco, John J., Broadway & Cooper st., Camden
Bowen, Robert N., Army
Braun, William, 406 Cooper st., Camden
Brennan, Charles L. S., 14 S. Broadway, Gloucester
Brennan, John P., 429 Cooper st., Camden
Brenneman, Richard E., 5056 Laurel rd.,Merch'tville
Brown, Stanley L., 517 Cooper st., Camden
Browning, Wm. J., 134 N. Centre st., Merchantville
Burns, Wilmer F., 267 White Horse Pike, Audubon
Bush, Ralph K., 23 E. Maple av., Merchantville
Butler, Samuel S., 1100 Kaighn av., Camden
Carlander Oswald R., 622 Cooper st., Camden
Casselman, Arthur J., 301 N. 2nd st., Camden
Chesnick, Reuben B., Army
Clark, Ernest W., 407 Cooper st., Camden
Clarke, R. Manning, 401 Wilson Bldg., Camden
Cohen, Paul, 500 State st., Camden
Collier, Martin H., Camden Co. T.B. Hosp., Lakel'nd
Conlen, Richard, 500 Haddon av., Camden
Cooper, Robert A., Army
Coxson, Harold P., Army
Crane, Reynold M., Navy
Crist, Walter A., Navy
Crowley, Joseph W., 4005 Westfield av., Camden
Cunningham, Joel B., 801 Cooper st., Camden
David, Leopold S., 1404 Baird av., Camden
Davis, Albert B., 511 Cooper st., Camden

Decker, Henry B., 527 Penn st., Camden
Deibert, Irvin E., 538 Cooper st., Camden
Del Duca, Vincent P., 514 Cooper st., Camden
Dempsey, J. Harvey, Army
Denbo, Elic A., 596 Benson st., Camden
Di Ielsi, Anthony J., Army
Donges, Clarence B., 442 Chambers av., Camden
Driscoll, Charles D., Army
Drossner, Jacob L., 1300 Park Blvd., Camden
Ebner, Paul G., 408 Overhill rd., Haddonfield
Ellis, Alexander, 513 Broadway, Camden
Ewing, Leslie H., 10 Broad st., Berlin
Eynon, Harold K., Army
Eynon, James R., W. Jersey Homeo. Hosp., Camden
Farrell, Edgar A. H., 504 Washington av., Haddonf'd
Fessman, John W., Clements Bridge rd., Runnemede
Filkins, Cedric E., 418 Whitehorse Pike, Audubon
Fisher, Stella C., 4401 Westfield av., Camden
Frantz, Max K., 624 S. 5th st., Camden
French, Harry J., 28 Franklin av., Merchantville
Fridrich, Harry E., 4172 Federal st., Camden
Friendenberg, Sidney, 2990 Alabama rd., Camden
Gamon, Robert S., 514 Cooper st., Camden
Geissler, Elmer E., 327 Monmouth st., Gloucester
German, George B., 15 W. Walnut av.,Merchantville
Gilbert, Philip D., 514 Cooper st., Camden
Girardo, Anthony J., 22 Taunton av., Berlin
Goldman, Samuel, 7th & State sts., Camden
Goldstein, Hyman I., 1425 Broadway, Camden
Gordon, Milton H., 12 N. 27th st., Camden
Gosper, Ralph W., 5719 W'stf'd av., Penns'kenTwp.
Grenhart, George W., 714 Market st., Camden
Griffey, William C., Army
Griscom, Lee E., 604 Broadway, Camden
Hadley, C. Frazer, 210 W. Maple av., Merchantville
Hadley, C. Frazer, Jr., 21 Haddon av., Westmont
Haines, Mabel C. S., 600 White Horse Pike, Audubon
Halbeisen, William A., 511 Cooper st., Camden
Hallinger, Earl S., 517 Cooper st., Camden
Hanson, Alfred S., 539 Monmouth st., Gloucester
Harbeson, James P., III, 403 Cooper st., Camden
Haury, Victor G., 206 Cedarcroft av., Audubon
Hays, Roy G., 567 Haddon av., Collingswood
Hemphill, Everett H., 274 Kings H'way, E., Had'nf'd
Hessert, Edmund C., 417 Cooper st., Camden
Hofer, William R., 125 Main st., Williamstown
Hollinshed, Beulah S., 600 Benson st., Camden
Howard, J. Edgar, 67 Kings H'way, W., Haddonf'd
Hughes, Arthur J., 3rd & Cooper sts., Camden
Hughes, Frank J., 429 Cooper st., Camden
Hughes, Thomas E., 223 Cooper st., Camden
Hummel, Ernest G., 414 Cooper st., Camden
Hummel, Merwin L., Navy
Husted, Gerald W., 306 Eighth av., Haddon Heights
Ironside, Paul A., 144 North dr., Haddonfield
Jack, H. Wesley, 538 Cooper st., Camden
Jackson, Chas. H., 1250 Park Blvd., Camden
Johnson, Herbert F., 429 Cooper st., Camden
Jones, John C., 805 Princeton av., Camden
Judson, G. Vernon, Jr., Army
Kain, Thomas M., 403 Cooper st., Camden
Keyser, David, Army
Kimler, William D., 400 Collings av., Collingswood
Klarich, Philip, 702 Broadway, Camden
Kline, Oram R., 514 Cooper st., Camden
Kraczyk, Michael J., 318 E. Main st., Moorestown
Kutner, Charles, 211 N. Fifth st., Camden
Larossa, Ernest A., 561 Benson st., Camden
Lashman, William M., 527 Cooper st., Camden
Lee, Benjamin F., Navy
Lee, Thomas B., 622 Cooper st., Camden
Lewis, Thomas K., 622 Cooper st., Camden
Locke, Henrik W., N. Y. Shipbuilding Corp., Camden
Lovett, Joseph C., Municipal Hospital, Camden
MacAlpine, Kenneth B., 500 Chews Ldg. rd.,Had'nf'd
Magee, Edward S., 201 White Horse Pike, Audubon
Magee, Russell S., 201 White Horse Pike, Audubon
Mahaffey, J. Lynn, 406 Warwick rd., Haddonfield
Maldeis, Albertos M. K., 117 N. Sixth st., Camden
Manser, Ernest E., 309 Haddon av., Collingswood
Marcarian, Henry G., 917 Cooper st., Camden
Martin, William, 300 Westmont av., Haddonfield
McCarthy, Arthur M., 2772 Federal st., Camden
McConaghy, Thomas P., 10th & Cooper sts., Camden
McDermott, Vincent T., 511 State st., Camden
McGlade, Thomas H., 1225 Walnut ave., W.Col'gsw'd
McWilliams, Charles E., Church st., Blackwood
Mecray, Paul M., 405 Cooper st., Camden
Mecray, Paul, Jr., 405 Cooper st., Camden
Meyer, George P., 410 Haddon av., Camden
Murray, Edwin N., 400 Penn st., Camden
Ondovchak, M. Frederic, Kings H'way, Mt. Ephraim
Ornaf, I. Edward, 1145 Thurman st., Camden
Osborn, Edward G., 3194 Alabama rd., Camden
Pike, Charles E., 4 E. Haddon av., Oaklyn
Pinsky, Harry A., Army
Platt, Edward V., 221 Eighth av., Haddon Heights
Pratt, Arthur G., 516 Cooper st., Camden
Price, Henry S., Jr., 123 Washington av., Collingsw'd
Principato, Roberto, 402 Walnut st., Camden
Rapp, Robert F., 932 Haddon av., Collingswood
Read, William T., Jr., Cooper Hospital, Camden
Reilly, Joseph, 604 White Horse Pike, Oaklyn
Rhone, David S., 1202 Haddon av., Camden
Riegert, Louis C., 808 Kings H'way, Haddon Hts.
Ristine, Edwin R., 123 Maple av., Westville
Roberts, Joseph E., Jr., 403 Cooper st., Camden
Rosner, Edwin, 788 Haddon av., Collingswood
Rudolph, John P., 108 W. Maple av., Merchantville
Russell, Karl S., Army
Ruttenberg, Max, 303 Cooper st., Camden
Samter, Max, 227 N. Center st., Merchantville
Schall, Reuben E., Seventh & Elm sts., Camden
Scheffler, Wilhelm A. H., 511 Cooper st., Camden
Schellenger, Edward A. Y., 429 Cooper st., Camden
Schrack, Helen F., 216 N. Fifth st., Camden
Schwartz, Henry C., Army
Seiberling, Joseph D., 225 Redman av., Haddonfield
Seto, Stanford P. T., Army
Shaen, Edward, 3024 Federal st., Camden
Shafer, Albert H., 405 Cooper st., Camden
Shafer, F. William, 634 Penn st., Camden
Sharp, Reuben L., 719 Cooper st., Camden
Shaw, Ernest B., 811 Collings av., W. Collingswood
Sheaffer, Clinton P., 241 Kings H'way, E., Had'nf'd
Shemeley, William G., Jr., 7 Haddon av., Camden
Sherk, A. Lincoln, 2647 Westfield av., Camden
Shipman, James S., 514 Cooper st., Camden
Shope, Edward P., 807 Wilson Bldg., Camden
Shull, Elliott C., 517 Cooper st., Camden
Sieber, Isaac G., 204 Merchant st., Audubon
Smith, Bertram H., Army
Smith, James D., 701 N. Sixth st., Camden
Smith, Wilbur A., Army
Snagg, William T., 719 Cooper st., Camden
Snape, William J., 573 Stevens st., Camden
Sochacki, Alexander, 1478 Mt. Ephraim av., Camden
Stein, Joseph M., 404A Boyd st., Camden
Stephenson, Daniel H., 2704 Westfield av., Camden
Stetser, Leland M., 920 Haddon av., Collingswood
Stone, Frank P., Laurel rd., Laurel Springs
Straus, Frederick W., 2708 Westfield av., Camden
Sufrin, Emanuel, 1529 Wildwood av., Camden
Summerill, Garnett, 330 Cooper st., Camden
Swiecicki, Martin E., Army
Tatem, Henry R., Jr., Pine st.&Atlantic av.,Audubon
Thompson, P. H., 4612 W'stf'd av., Pennsauken Twp.
Traganza, Robert W., 428 Richey av., W.Collingsw'd

Vaughan, James M., 825 Kaighn av., Camden
Warwick, Ralph A., 3300 Federal st., Camden
Watkins, George R., La Pierre rd., Magnolia
Waugh, Bascom S., 1882 S. 10th st., Camden
Weigert, Wolfgang U., 266 Marlton av., Camden
Weimann, Max L., 803 Station av., Haddon Heights
West, David H., Navy
Whalen, Edward C., 942 Cooper st., Camden
Wheatland, Marcus F., Jr., 757 Kaighn av., Ca
Wiant, Herman E., 120 Windsor av., Haddonfiel
Wiggins, Ulysses S., 1025 S. Fourth st., Camden
Wilson, Lester R., 3320 Federal st., Camden
Winter, Carl M., 1518 Collings rd., Camden
Wright, Ralph S., 517 Cooper st., Camden
Wroblewski, Benj. M., 1166 Thurman st., Camden

Number of Active Members and basis of representation, 205.

HONORARY MEMBERS

Clements, Lavinia B., Haddonfield
Day, Grafton E., Collingswood
Eaton, Arthur T., Haddon Heights
Lyon, Leslie C., Magnolia
Marcy, John W., Merchantville
Osmun ,Milton M., Audubon
Pratt, William H., Camden
Van Sciver, John E. L., Haddonfield

CAPE MAY COUNTY (5)

Society organized December 18, 1883. Eight regular meetings each year. Meets on fourth Tuesday, October to May inclusive. Semi-annual meeting in October. Annual Meeting in May.

ACTIVE MEMBERS

Bernheisel, Louis E., Army
Brooks, George M., Cape May Court House
Cameron, C. Paul, Army
Cohen, Maurice B., Pine & Pacific avs., Wildwood
Cooper, Jules, 723 Washington st., Woodbine
Crowe, Aldrich C., 735 Atlantic av., Ocean City
Cryder, Millard C., Army
Dandois, George F., 220 E. Wildwood av., Wildwood
Darby, C. Eugene, 620 Atlantic av., Ocean City
Eisenhower, J. S. D., 154 E. Spicer av., Wildwood
Fath, Marcus A., 200 W. Poplar av., Wildwood
Haines, F. B. Lane, 503 Ninth st., Ocean City
Haines, Willits P., 503 Ninth st., Ocean City
Hirsch, Arthur, 811 DeHirsch av., Woodbine
Hornstine, Harry H., 4004 Pacific av., Wildwood
Hughes, Frank R., 29 Ocean st., Cape May
Hughes, Harold F., 29 Ocean st., Cape May
Hughes, Samuel B., 246 E. Pine av., Wildwood
Mace, Margaret, 2410 Atlantic av., N. Wildwood
Markowitz, Isidor, 115 Broadway, West Cape May
Monosson-Friedland, Ida, 200 N. East av., Vineland
Moon, Alexander C., 126 Decatur st., Cape May
Pettit, Herschel, 807 Wesley av., Ocean City
Smith, Marcia V., 821 Wesley av., Ocean City
Snyder, James A., Ocean & Hughes sts., Cape May
Steel, Wm. A., 3300 N. Broad st., Philadelphia, Pa.
Townsend, John B., 824 Wesley av., Ocean City
Way, Clarence W., 4515 Landis av., Sea Isle City
Whitcar, John H., Box 235, Ocean City
Yingling, Paul L., 412 Eighth st., Ocean City

Number of Active Members and basis of representation, 30.

HONORARY MEMBERS

Diverty, Henry B., Woodbury
Quigley, Frederic J., Union City
Ulmer, Chester I., Gibbstown

CUMBERLAND COUNTY (6)

Society organized June 16, 1816. Meets on the second Tuesday of October, December, February, April and June. Annual Meeting in April. Special scientific meetings are held in the evening in November, January, March and May.

ACTIVE MEMBERS

Aitken, Frank J., 176 W. Commerce st., Bridgeton
Anastor, Herbert C., 641 Wood st., Vineland
Bacon, Mary, 278 E. Commerce st., Bridgeton
Baker, Hugh W., 8th & Elmer sts., Vineland
Bellak, Ellis R., Leesburg
Berkowitz, Benjamin, 188 E. Commerce st.,Bridgeton
Bostwick, Delazon S., Cumberland Hotel, Bridgeton
Branin, Howard S., 200 W. Main st., Millville
Butcher, Charles, Heislerville
Corson, Kenneth E., 25 S. Myrtle st., Vineland
Cunningham, Charles, Jr., E .Landis av., Vineland
Davies, George A., 53 Front st., Elmer
Day, Samuel T., Main st., Port Norris
DeSantis, Orazio J., Army
Friedland, Arnold J., 200 N. East av., Vineland
Fromkin, Charles, 20 Bank st., Bridgeton
Garrison, W. Sherman, Main st., Cedarville
Gray, Charles M., 6th & Grape sts., Vineland
Greene, Edwin C., 61 N. Pearl st., Bridgeton
Gricco, Anthony L., 830 Elmer st., Vineland
Henry, Norman, 739 Wood st., Vineland
Hirsch, Allen H., 10 N. 6th st., Vineland
Kauffmann, Louis J., 228 N. 2nd st., Millville
Knowles, James S., 318 N. Second st., Millville
Kolbe, Joseph T., 119 S. Second st., Millville
Kratka, William H., 188 N. Pearl st., Bridgeton
Kump, Albert B., 31 W. Commerce st., Bridgeton
Loder, Horace B., 225 E. Commerce st., Bridgeton

Loper, John C., 129 Atlantic st., Bridgeton
Lore, Harry E., Main st., Cedarville
Lyon, Earl C., 194 E. Commerce st., Bridgeton
Magolda, Anthony F., 727 Grape st., Vineland
Marchione, Nicholas E., 105 S. East av., Vineland
Mayhew, Charles H., 329 Pine st., Millville
Mezzetti, Alfred F., 220 S. 6th st., Vineland
Miller, H. Garrett, 203 E. Main st., Millville
Myatt, Leslie E., 98 N. Pearl st., Bridgeton
Neal, Charles B., Pine & 3rd sts., Millville
Palladino, Alessandro, 86 W. C'mm'rce st., Bridgeton
Pastore, Mario, East av. & Grape st., Vineland
Pino, Anthony, 196 Irving av., Bridgeton
Ramsey, F. Muriel, 310 E. Pine st., Millville
Reeves, J. Franklin, 55 East av., Bridgeton
Rosen, Sol, 214 N. Second st., Millville
Rosenthal, Bernice D., Army
Schwartz, Leon J., Army
Scott, Leonard G., 496 E. Commerce st., Bridgeton
Sharp, Charles E., Main st., Port Norris
Sheppard, Alfred G., 309 Broad st., Elmer
Sheppard, Muse A., 102 Main st., Elmer
Sheppard, Thomas S., 21 E. Vine st., Millville
Shirlock, Margaret E., Army
Siegel, Sidney L., 227 N. 2nd st., Millville
Thalheimer, Edward J., 7th & Plum sts., Vineland
Thomas, George N., 712 Wood st., Vineland
Walker, Ada H., 635 Landis av., Vineland
Walker, H. Burton, 635 Landis av., Vineland
Ware, Carl N., Bridgeton rd., Shiloh
Whaland, Berta, 117 Atlantic st., Bridgeton
Wilson, Charles W., 636 Wood st., Vineland
Wilson, Herbert H., 24 Bank st., Bridgeton
Winslow, John H., 27 S. Valley av., Vineland
Woodruff, Dare, 611 Elmer st., Vineland

Number of Active Members and basis of representation, 63.

HONORARY MEMBERS

Cornwell, Alfred, Bridgeton
Elmer, Matthew K., Bridgeton
Simkins, Raymond, Bridgeton
Weithaase, Helen E., Vineland

ESSEX COUNTY (7)

Society organized June 4, 1816. Meets second Thursday of each month, October to May, inclusive. Annual Meeting is second Thursday in May.

ACTIVE MEMBERS

Abbamonte, Louis W., 226 N. Park st., East Orange
Abel, Arthur R., Orange Memorial Hosp., Orange
Abrams, Abram B., 299 Clinton av., Newark
Adelman, Benjamin B., 190 Clinton av., Newark
Adelman, Nathan, Army
Agnew, Hobart M., 17 Plymouth st., Montclair
Albano, Edwin H., Army
Albano, Frank J., 535 N. Seventh st., Newark
Albano, Joseph, 535 N. Seventh st., Newark
Alexander, Walter G., 48 Webster pl., Orange
Alford, Ralph I., Army
Allan, James S., 144 Harrison st., East Orange
Allen, Chester B., Jr., 42 Gordonhurst av., Montclair
Allen, Raymond N., 144 Harrison st., East Orange
Alling, Frederic A., 15 Washington st., Newark
Altman, Charles D., 63 Forest Hill rd., West Orange
Ambrose, Anthony, 31 Lincoln Park, Newark
Anderson, Robert C., 686 Mt. Prospect av., Newark
Anderson, William A., 1310 Broad st., Bloomfield
Angelillo, Marc C., 169 Bloomfield av., Newark
Antonius, Nicholas A., 27 W. Market st., Newark
Antopol, William A., Army
Anuario, Charles B., 365 S. Center st., Orange
Applebaum, Irving L., 31 Lincoln Park, Newark
Areson, Wm. H., 153 Bellevue av., Upper Montclair
Arons, Harry, 31 Lincoln Park, Newark
Ash, Samuel, 866 So. 13th st., Newark
Asher, Maurice, 186 Clinton av., Newark
Aszody, Paul, 340 Waverly av., Newark
Auerbach, Friedrich, 490 Stuyvesant av., Irvington
Bachmann, William, 87 Hillcrest ter., East Orange
Bacote, Ernest F., 78 Barclay st., Newark
Bagg, Linus W., 31 Lincoln Park, Newark
Baime, Jules E., 25 S. Munn av., East Orange
Baiocchi, Pascal J., 203 Hunterdon st., Newark
Baird, Thompson M., 939 Bay av., Point Pleasant
Baker, Maclyn F., 987 Sanford av., Irvington
Baldwin, Samuel H., 626 Clinton av., Newark
Balis, Samuel B., 27 So. Ninth st., Newark
Balsamo, Joseph J., 224 So. Eighth st., Newark
Balson, Zachary D. B., Army
Barbella, Joseph D., Navy
Barkhorn, Charles W., Army
Barkhorn, Henry C., 45 Johnson av., Newark
Barnard, Frank G., Army
Barrett, John E., 25 Elwood pl., Newark
Barrett, Joseph F., 230 Parker av., Maplewood
Bass, Rose D., 54 Lyons av., Newark
Baum, Felix, 10 Elm court, South Orange
Baum, Lewis F., Army
Baum, Samuel, 10 Osborne ter., Newark
Bauman, Everett O., 24 Girard pl., Newark
Bauman, Rush C., 92 High st., Nutley
Becker, Martin, 10 Baldwin st., East Orange
Beer, Sanel, 48 Wilson av., Newark
Beling, C. Abbott, 15 Washington st., Newark
Beling, Christopher C., 111 Clinton av., Newark
Bell, Horace O., Essex Co. Isolation Hosp., Belleville
Bell, Thomas, 340 Belmont av., Newark
Belott, Louis V., 529 Park av., Orange
Bender, Louis, 285 Ridgewood av., Newark
Bengelsdorf, Aron, 29 Clinton pl., Newark
Berardinelli, Carmine G., 92 Eighth av., Newark
Berg, Samuel, Army
Berger, William A., 346 Roseville av., Newark
Bergman, Meyer W., 31 Lincoln Park, Newark
Berlin, Morris R., 84 Girard pl., Newark
Berman, H. Robert, 299 Clinton av., Newark
Berney, Irving, 31 Lincoln Park, Newark
Berney, Ruth V., 16 Lyons av., Newark
Bernhard, William G., Army
Bernstein, Arthur, 668 Clinton av., Newark
Bernstein, Julius, 584 S. Tenth st., Newark
Besson, Franklin J., Navy
Beyer, Othmar J., 42 Laurel av., Irvington
Bianchi, Angelo R., 184 Hunterdon st., Newark

Bigelow, Nelson S., Navy
Binder, Charles I., 188 Oakland rd., Maplewood
Birdsall, Clarence A., 9 Smull av., Caldwell
Bissett, John V., 29 Hawthorne av., East Orange
Biunno, Anthony J., 53 Finlay pl., Newark
Blackburne, George, 490 Central av., Newark
Blanchard, Kenneth, 144 Harrison st., East Orange
Blaustein, Maurice L., 859 S. 13th st., Newark
Bleiberg, Jacob, 31 Lincoln Park, Newark
Block, Marcus T., 177 Bloomfield av., Newark
Block, Max, 48 N. Fullerton av., Montclair
Block, Milton, 342 Union av., Irvington
Bocchini, Joseph A., Army
Bokor, Emery, 819 S. 12th st., Newark
Bolten, Bernard, 291 Osborne ter., Newark
Bonomo, Michael J., 587 S. 10th st., Newark
Borsher, Irving P., Army
Bove, Joseph, 306 Lincoln av., Orange
Brackett, Elizabeth R., 371 Franklin av., Nutley
Bradford, Stella S., 26 N. Mountain av., Montclair
Brams, William M., 7 Madison av., Newark
Brandman, Otto, 39 S. Munn av., East Orange
Braun, Gustav A., 24 Centre st., South Orange
Breitstadt, Charles A., 157 Elwood av., Newark
Bremer, Kenneth M., 94 S. Munn av., East Orange
Brien, William M., 449 Main st., Orange
Briggs, Henry, 144 Harrison st., East Orange
Brim, Anne S., Edgemere Hotel, East Orange
Broadnax, Mary E., 140 Roseville av., Newark
Brodkin, Eva T., 365 Osborne ter., Newark
Brodkin, Henry A., 365 Osborne ter., Newark
Brooke, Charles R., Army
Brooks, Clyde, 105 Broad st., Newark
Brotman, Harry, 808 S. 11th st., Newark
Brotman, Morton M., 90 Avon av., Newark
Brown, Chester R., 22 Midland av., Arlington
Brown, Chester T., Prudential Ins. Co., Newark
Brown, Edward V., 9 Park av., Caldwell
Brown, Harold W., 27 S. Fullerton av., Montclair
Brown, Lewis W., 160 Roseville av., Newark
Browne, George F., 284 Highland av., UpperMontcl'r
Bruning, Richard H., Navy
Brunkow, Charles D., 31 Lincoln Park, Newark
Buckley, Jeremiah L., Army
Buckner, Roscoe W. H., 20 Rose st., Newark
Buermann, August, III, Navy
Bull, Louis M., 92 Heller Parkway, Newark
Bull, William J., 98 Park st., Montclair
Burke, Leonard P., 30 Lakeside av., Verona
Burke, Stephen E., 212 First av., Newark
Burne, John J., 17 Gould av., Newark
Burpeau, William P., 80 Woodland av., East Orange
Burrill, Benjamin B., Jr., Navy
Burstein, Frank, 31 Lincoln Park, Newark
Burstein, Leo Q., 702 S. 15th st., Newark
Burstein, Rachel, 31 Lincoln Park, Newark
Busch, Herman, 38 Johnson av., Newark
Bush, Archer C., 40 Union st., Montclair
Butan, Lonis, Army
Buvinger, Charles W., 50 Washington st., E. Orange
Byck, Louis, 794 S. 11th st., Newark
Byrnes, Elizabeth W., 160 Central av., Orange
Bythewood, Alton E., Jr., 145 W. Market st.,Newark
Cacciarelli, Robert A., 517 Roseville av., Newark
Caggiano, Anthony P., Navy
Cahill, Laurence A., 361 Lafayette st., Newark
Calasibetta, Charles J., 37 Longfellow av., Newark
Caldwell, Donald M., Army
Caldwell, Julius A., 45 S. Mountain av., Montclair
Calvert, William C., 225 Gregory av., West Orange
Camche, Leo J., 250 Renner av., Newark
Cameron, Arthur E., 59 Somerset st., Newark
Cameron, Edwin A., 186 S. Burnett st., East Orange
Campbell, Everette L., 144 Harrison st., East Orange
Campbell, William, 144 Harrison st., East Orange
Cantalupo, Emidio, 95 Nichols st., Newark
Cantelmo, Alphonse L., 144 Harrison st.,EastOrange
Caprio, Orlando G., Army
Caputo, Anthony R., 301 Washington av., Belleville
Carbone, Francesco N., 440 Central av., Orange
Cardwell, Edgar P., 965 Broad st., Newark
Carlisle, Paul E., 763 Broad st., Newark
Carman, Fletcher F., 21 Parkway, Montclair
Carpenter, Charles A., 30 Francis pl., Caldwell
Carr, Josephus C., 75 13th av., Newark
Carrigan, Francis P., Army
Carrol, Wilfred, 51 Ingraham pl., Newark
Casale, John B., 359 Bloomfield av., Newark
Cassini, Henry C., 27 Tremont av., East Orange
Castellano, Martin G., 330 Roseville av., Newark
Cerone, Daniel M., 138 N. Arlington av., E. Orange
Cerreto, Frank R., 395 Roseville av., Newark
Cestone, Canio, 521 Pompton av., Cedar Grove
Cetrulo, Gerald I., 234 Mt. Prospect av., Newark
Chamberlain, Aims R., 30 Lenox pl., Maplewood
Chamberlain, Richard R., 30 Lenox pl., Maplewood
Champlin, Paul M., 43 S. Arlington av., East Orange
Chapman, Robert W., 195 Boyden av., Maplewood
Chattin, J. Franklin, 195 Boyden av., Maplewood
Cherashore, Harry N., 363 Centre st., Nutley
Chernus, Jack, 279 Meeker av., Newark
Cheskin, Louis J., 915 Hunterdon st., Newark
Chiger, Alexander S., 621 High st., Newark
Chimacoff, Hyman, 101 Clinton av., Newark
Chmelnik, Abraham G., Navy
Christoph, Francis T., 483 Prospect st., Maplewood
Ciccone, Edwin L., 261 Roseville av., Newark
Citrino, Robert J., 345 Centre st., Nutley
Clarken, Joseph A., 27 Ingraham pl., Newark
Clement, Baxter L., 15 Washington st., Newark
Clinton, Joseph A., 339 Park av., Newark
Coburn, J. Wesley, 259 Park av., East Orange
Coffin, Henry F., 116 N. Ninth st., Newark
Coghlan, Jasper, 540 Parker st., Newark
Cohen, I. Elvin, 561 Elizabeth av., Newark
Cohen, Maurice, 106 Valley rd., Montclair
Cohen, Max, 60 Ridge rd., North Arlington
Cohen, Meyer J., 118 Johnson av., Newark
Cohen, Sidney A., Army
Cohen, Sidney L., 29 Girard pl., Newark
Cohen, Sidney P., 509 Franklin av., Nutley
Cohn, George M., 867 S. 11th st., Newark
Cohn, Hermann, 393 Clinton av., Newark
Cohn, Royal M., 740 Clinton av., Newark
Coleman, Russell M., Army
Colmer, M. Jonas, Army
Colsh, LeRoy L., 612 Ridgewood rd., Maplewood
Colton, Ethan T., Jr., 38 Park st., Montclair
Comando, Harry N., 690 Clinton av., Newark
Conlon, Philip J., 25 James st., Newark
Connamacher, Harold S., 671 Springfield av.,Newark
Connolly, John J., 180 Ballantine Pkwy., Newark
Connolly, Richard N., 117 Fifth st., Newark
Cook, Hugh F., 21 Roseville av., Newark
Cooper, David P., 62 S. 10th st., Newark
Cooperman, William, 647 Market st., Newark
Cordasco, Peter, 517 Roseville av., Newark
Cornish, Charles H., 673 Prospect st., Maplewood
Coughlan, Ella A., 10 Oakwood av., Orange
Coughlin, Frank J., 100 Magnolia av., Arlington
Covino, Louis L., 44 Oakland ter., Newark
Cox, John C., 55 Woodland rd., Maplewood
Cox, William W., 79 S. Fullerton av., Montclair
Crane, Charles G., 78 Farley av., Newark
Crapanzano, Domenico, Essex Co. Hosp.,CedarGrove
Crawford, Georgina U., 65 Prospect st., E. Orange
Crecca, Anthony D., 376 Roseville av., Newark
Crecca, William D., 111 Park av., Newark

Cregar, John S., 150 Harrison st., East Orange
Crossfield, Henry C., 144 Harrison st., East Orange
Crystell, Edward H., 4 Hawthorne av., Nutley
Cucinella, Anthony B., 361 Lafayette st., Newark
Curtis, Arthur W., 144 Harrison st., East Orange
Curtis, Elbert A., 65 Central av., Newark
D'Addario, Anthony R., 132 Broadway, Newark
D'Agostini, Alfred J., Army
D'Agostini, Robert J., 304 W. Market st., Newark
D'Alessandro, Arthur J., 15 Salem st., Newark
D'Ambola, Philip R., 21 S. Sixth st., Harrison
D'Amico, Thomas V., 70 Fairview av., Verona
Dane, Charles, 61 Scotland rd., South Orange
Dane, John, 61 Scotland rd., South Orange
D'Angelo, Joseph C., 330 Washington av., Belleville
Dann, Frederick J., 25 Girard pl., Newark
Dante, Pasquale, 393 Millburn av., Millburn
Danzis, Louis, 31 Lincoln Park, Newark
Danzis, Maximillian, 31 Lincoln Park, Newark
Darby, I. Kermit, 1 Convent av., N. Y. C.
Darden, Walter T., 149 W. Kinney st., Newark
Daron, Simeon, 31 Lincoln Park, Newark
Davidson, Henry A., 3 Beach st., Maplewood
Davidson, Maurice M., 128 Grant av., E., Roselle Pk.
Davies, George W., 35 Fairview av., Verona
Davis, Louis, 825 S. 10th st., Newark
Davis, Thomas C., 30 Old Short Hills rd., Millburn
Dear, Abraham L., 23 Synott pl., Newark
DeFronzo, Morando, 180 Fairmount av., Newark
DeGerome, James H., 10 Ridgewood av., Glen Ridge
DeHart, George K., 132 Sunset av., Verona
Deignan, William L., 257 Dodd st., East Orange
Delaney, Oscar M., 59 Seely av., Arlington
Del Deo, Nicholas V., 49 State st., Newark
DeLeonardis, James V., 94 Jefferson st., Newark
Del Guercio, Olindo, 342 Clifton av., Newark
DeLia, Emilio, 25 Crane st., Newark
Della Ragione, Mario, 120 Second av., Newark
Del Negro, Albert E., 402 Roseville av., Newark
DeMichele, Roland V., 436 Ridge st., Newark
Denes, Oscar, 402 Centre st., Nutley
DePalma, Anthony F., Navy
DePhillips, Benedict R., 228 Clifton av., Newark
Dessauer, Joseph, 105 Shanley av., Newark
DeTroia, Frederick C., 40 12th av., Newark
Deutel, Oscar R., 283 Franklin st., Bloomfield
DeVincentis, Henry, 285 Henry st., Orange
Devlin, Arthur D., 138 Isabella av., Newark
Devlin, Hugh J., 72 Thomas st., Newark
Dias, Joseph L., 17 Lombardy st., Newark
Dieffenbach, Richard H., 570 Mt.Prosp't av.,Newark
Diener, Samuel, Army
DiFino, Felix J., 463 N. Seventh st., Newark
DiGiacomo, Harry E., 195 Hunterdon st., Newark
DiGiacomo, William H., 223 Fairmount av., Newark
Dinge, Ferdinand C., 67 S. Munn av., East Orange
DiNorcia, Joseph, 498 W. Market st., Newark
Donahue, William J., 71 S. Ninth st., Newark
Donchi, Sol M., 9 Madison av., Newark
Donnelly, John H., Army
Dowds, Samuel C., 218 Walnut st., Montclair
Dranow, Paul, 233 Franklin av., Nutley
Drapkin, Berta, 31 Lincoln Park, Newark
Dreskin, Jacob L., 172 Lyons av., Newark
Drewniany, Bernardine, 548 Page av., Lyndhurst
DuBois, Morris G., 769 High st., Newark
Duffy, Edward P., Jr., 158 Beech st., Nutley
Dulany, Theodore L., 170 W. Market st., Newark
Dulin, Everett V., 144 Harrison st., East Orange
Dunn, Theodore B., Army
Durchlag, E. Nelson, 12 Myrtle av., Irvington
Dwork, Harold K., 1 Hansbury av., Newark
Eagleton, Wells P., 15 Lombardy st., Newark
Ebenfeld, Samuel W., 344 High st., Newark
Echikson, Joseph I., 31 Lincoln Park, Newark
Eck, Daniel B., 144 Harrison st., East Orange
Edelen, James J., 100 S. Munn av., East Orange
Ehrlich, Edward, 838 S. 13th st., Newark
Ehrlich, William E., 31 Lincoln Park, Newark
Eichler, Bernard B., 221 Midland av., Montclair
Ein, William B., 31 Lincoln Park, Newark
Einhorn, Samuel E., 241 16th av., Newark
Eisenberg, David S., 31 Lincoln Park, Newark
Eisenstodt, Lester W., 31 Lincoln Park, Newark
Ellis, Arthur J., 282 Broad st., Newark
Emerson, Linn, 303 Park av., Orange
Enmer, S. Wolfe, 31 Lincoln Park, Newark
Englander, Charles, 41 Hillside av., Newark
English, John T., 110 Yale av., Irvington
Epstein, Harry B., 31 Lincoln Park, Newark
Epstein, William M., Army
Erdman, George L., Army
Erler, Robert E., 360 Prospect st., South Orange
Ervin, Millard B., 36 Canterbury lane, Westfield
Etheridge, Charles H., 433 Prospect st., East Orange
Evans, Charles H., 144 Harrison st., East Orange
Evans, David P., 144 Harrison st., East Orange
Ewing, Harvey M., 31 Trinity pl., Montclair
Fader, Ferdinand, 350 Springdale av., East Orange
Fager, Rudolph O., 53 Park pl., Bloomfield
Failing, Brayton E., 31 Lincoln Park, Newark
Fanburg, Sol J., 31 Lincoln Park, Newark
Farkas, Morris, 163 High st., West Orange
Farr, Irving L., 214 Walnut st., Montclair
Fasano, Giovanni, 194 S. Seventh st., Newark
Faughnan, Rose C., 97 High st., Passaic
Fava, Philip V., 355 Sanford av., Newark
Fechner, Julius, 362 Clinton av., Newark
Fein, Bernard, 585 Elizabeth av., Newark
Feinsod, Samuel N., 1305 Clinton av., Irvington
Feldman, Frank H., Army
Fendrick, Edward, 17 Watson av., East Orange
Fern, Samuel S., 122 Elizabeth av., Newark
Feuer, Joseph A., 653 Elm st., Arlington
Filippone, Ames L., 171 Clifton av., Newark
Fink, A. Elston, 489 High st., Newark
Fink, Irving E., 71 Lincoln Park, Newark
Finkel, Joshua, 853 S. 11th st., Newark
Finkelstein, Abe S., 670 Clinton av., Newark
Finkler, Rita S., 35 Leslie st., Newark
Finnerty, Urban R., 71 Park st., Montclair
Fischbein, Martin M., 110 Yale av., Irvington
Fischer, David D., 266 Millburn av., Millburn
Fischer, Edward J., 29 Ashwood ter., West Orange
Fischer, Louise, 31 Lincoln Park, Newark
Fischman, Harold H., 326 Avon av., Newark
Flanagan, James F., Navy
Flanagan, John J., Army
Flax, Charles H., 71 Baldwin av., Newark
Flax, Ira I., 890 S. 16th st., Newark
Flax, Jacob L., 31 Lincoln Park, Newark
Fleischmann, Viola G., 103 Scotland rd., S. Orange
Fleming, Joseph A., 247 Claremont av., Montclair
Floody, Robert J., 324 Kingsland st., Nutley
Flower, Morrie A., 39 Lincoln Park, Newark
Flynn, Edward A., 176 Washington av., Belleville
Foley, James F., Army
Ford, Theodore R., 144 Harrison st., East Orange
Forsyth, Kenneth C., 8 Ziegler Tract, Carneys P't
Fort, J. Irving, 306 Roseville av., Newark
Forte, Daniel L., 36 Nevins st., Rutherford
Forte, Frank S., 318 Roseville av., Newark
Fortunato, Samuel J., 21 Abbotsford av., Newark
Fost, William H., 107 Franklin st., Belleville
Foster, Herbert W., 2 Erwin Park, Montclair
Fowler, Royale H., 744 Broad st., Newark
Frame, Dorothy L., 15 Highland av., Glen Ridge
Francy, Donald G., Army

Frank, Simon C., 62 Ridge rd., North Arlington
Franklin, Frank A., Army
Fratantuno, Michael J., 14 Vermont av., Newark
Freeman, George C., Army
Freeman, Richard D., 317 Carteret pl., Orange
Freinkel, Jacob, 2 Hillside av., Newark
Friedlander, Kurt F., 25 S. Munn av., East Orange
Friedman, Harry, Navy
Friedman, Hyman, 1096 Sanford av., Irvington
Friedman, Milton, Army
Friedrich, Adam H., Navy
Fritsch, Alfred, 82 Lyons av., Newark
Froelich, Joseph C., 74 Ingraham pl., Newark
Fruchtbaum, Robert P., Navy
Furman, Benj. A., 31 Roseville av., Newark
Furst, Nathan J., 299 Clinton av., Newark
Galioto, Frank M., 5 Bloomfield av., Belleville
Gamba, Joseph, 388 Fairmount av., Newark
Gambacorta, Leopoldo, 397 N. 13th st., Newark
Ganley, Arthur J., 390 Park av., East Orange
Ganot, Frank I., 392 Ridge st., Newark
Gardam, Joseph W., 16 Longfellow av., Newark
Gardner, Kenneth E., 45 Fremont st., Bloomfield
Gaylor, Earl L., Jr., 144 Harrison st., East Orange
Geannette, Ernest D., 14 Harrison av., Montclair
Gehl, Sidney H., 65 Wolcott ter., Newark
Gelb, Jerome, Army
Geller, Samuel, 696 High st., Newark
Gencher, Benjamin, Army
Gennell, Ernest, 298 Parker st., Newark
George, Melbourne E W., 744 Broad st., Newark
Gerard, Patrick D., 364 Roseville av., Newark
Gerhardt, Paul E., 718 S. 17th st., Newark
Gershenfeld, David B., 20 Hillside av., Newark
Giardina, John S., 341 Walnut st., Newark
Giardina, Vincent J., 11 Hill st., Newark
Gibbins, A. Leslie, 60 Roseville av., Newark
Giffoniello, Arthur A., 334 Roseville av., Newark
Gifford, William R., 247 Park av., East Orange
Gilbert, Harold F., 626 Schuyler av., Arlington
Gilbert, Samuel M., 353 Washington av., Belleville
Gilligan, Walter W., Army
Gilman, Chas. M. B., Blossom Cove rd., Red Bank
Gilmour, John R., Navy
Giuffra, Frank, 161 Park st., Montclair
Giuliana, Robert A., 31 Central av., Newark
Glass, Oscar, 838 S. 12th st., Newark
Glass, William H., 144 Harrison st., East Orange
Glazier, Jesse T., 670 Sanford av., Newark
Gluckman, I. Edward, 78 Johnson av., Newark
Gluckman, Saul K., 78 Johnson av., Newark
Glynn, S. Robert, 865 S. 11th st., Newark
Godfrey, Alan O., Navy
Goeller, Jacob D., 1165 W. Clinton av., Irvington
Goffman, Emanuel, 316 Claremont av., Montclair
Goldberg, Harold H., 814 S. 10th st., Newark
Goldberg, Louis E., 31 Lincoln Park, Newark
Goldberg, Samuel A., 169 Gregory av., W. Orange
Golden, Clement H., 109 Weequahic av., Newark
Goldman, Jerome, 299 Clinton av., Newark
Goldman, Lester M., 53 Leslie st., Newark
Goldmann, Joseph, 103 N. Walnut st., East Orange
Goldstein, Henry Z., 31 Lincoln Park, Newark
Goldstein, Samuel M., 40 Johnson av., Newark
Goldstein, William H., 632 Belgrove dr., Arlington
Goodman, Kenneth, 141 Park av., East Orange
Gordon, A. Julius, 351 Roseville av., Newark
Gorten, Manfred L., 669 Elizabeth av., Newark
Grant, Francis, Army
Grant, William F., 309 Roseville av., Newark
Grasso, Anthony P., Army
Gray, John W., 142 Clinton av., Newark
Greenberg, Jacob L., 189 16th av., Newark
Greenberg, Samuel, 46 Johnson av., Newark
Greenfield, Bernard H., 691 Clinton av., Newark
Greenfield, Herbert, 31 Lincoln Park, Newark
Greenfield, Leonard S., 691 Clinton av., Newark
Greenwald, Theo. L., 44 Maple av., Morristown
Greenwood, Samuel B., 190 Clinton av., Newark
Greer, Melvin A., 190 Washington st., Bloomfield
Gregorius, Ralph F., 120 Irvington av., So. Orange
Gregory, Mildred G., 64 N. Ninth st., Newark
Greifinger, Marcus H., 31 Lincoln Park, Newark
Greifinger, William, 22 Vassar av., Newark
Griffin, Guy B., 197 S. Centre st., Orange
Griffith, Roy, 909 Broad st., Newark
Gross, Irving, 16 Grove av., Verona
Grossblatt, Philip, 31 Lincoln Park, Newark
Gruber, William L., Army
Grubin, Harold, Army
Grundorfer, Joseph, 201 Lyons av., Newark
Grunt, Louis, 80 Millington av., Newark
Gulick, James B., Navy
Gullord, Edward G., 284 Bellevue av., UpperMontcl'r
Gutowski, Walter T., 104 Grove ter., Irvington
Hadley, Elinor E., 5 Mountain av., Maplewood
Hagen, Walter H., 179 Lincoln av., Orange
Hagman, Frank E., Army
Hahn, Katherine B., 372 Thornden st., South Orange
Hahn, William H., 15 Lombardy st., Newark
Haley, Paul W., 719 Sanford av., Newark
Haller, Olga, 182 Roseville av., Newark
Halpern, Melvin M., 493 Central av., Newark
Halpern, William, Army
Halprin, Harry, Navy
Halsey, Levi W., 61 Church st., Montclair
Hamilton, Robert G., 92 Main st., Orange
Hanan, James T., 11 The Crescent, Montclair
Hand, Frederick G., 437 Ridgewood rd., Maplewood
Hansen, Harold T., 533 Mt. Prospect av., Newark
Hantman, Harold, 196 Roseville av., Newark
Harden, Albert S., 510 W. Market st., Newark
Harden, Albert S., Jr., 551 Ridgewood rd., Maplew'd
Harman, Byron M., Frenchtown
Harris, Morris, Army
Hartman, Winfield L., Jr., 2 Elm court, So. Orange
Harvey, Robert K., 711 Kearny av., Arlington
Harvey, Thomas W., Jr., 59 Main st., Orange
Haschec, Walter, 690 S. 19th st., Newark
Haskin, Aaron H., 22 Goldsmith av., Newark
Hasney, Frederick A., 292 Main st., West Orange
Hatcher, George A., Essex County Hosp., Verona
Hauck, Lydia R. B., 644 Stuyvesant av., Irvington
Hauck, William H., 644 Stuyvesant av., Irvington
Hawkes, E. Zeh, 84 Washington st., Newark
Hawkes, Stuart Z., 84 Washington st., Newark
Hayes, Gerald W., Army
Heineken, Theodore S., 17 Park pl., Bloomfield
Heller, Abraham R., 494 Belgrove dr., Arlington
Heller, Nathan B., 31 Lincoln Park, Newark
Hendlich, Milton G., 24 Johnson av., Newark
Henle, Carye-Belle, 31 Lincoln Park, Newark
Hennig, Paul F., 688 Stuyvesant av., Irvington
Hermann, John H., 197 S. Centre st., Orange
Herndon, Lewis S., 144 Harrison st., East Orange
Herold, Harvey T., 850 S. 13th st., Newark
Hersh, David H., Navy
Hewson, George F., Navy
Heyman, Arthur, 79 Baldwin av., Newark
Hicks, Alfred M., 65 N. Fullerton av., Montclair
Higi, Joseph E., 15 Pomona av., Newark
Hill, James O., 84 Barclay st., Newark
Hill, Robert H., 227 Roseville av., Newark
Hilton, Clarence O., 556 N. Seventh st., Newark
Hinckley, Livingston S., 182 Clinton av., Newark
Hirsch, Theodore, 842 S. 13th st., Newark
Hobart, Richard T., 454 Park st., Upper Montclair
Holderith, Albert E., 15 Virginia av., Livingston

Holler, Henry G., 234 Montclair av., Newark
Holmes, George J., 17 Elizabeth av., Newark
Holtz, Harry M., 299 Clinton av., Newark
Hooton, Thomas C., 31 Trinity pl., Montclair
Hopping, Richard A., Navy
Horland, Aaron H., 37 Chancellor av., Newark
Horn, Harry, 622 Stuyvesant av., Irvington
Horn, Max, 850 S. 11th st., Newark
Hosp, Paul H., 842 S. 12th st., Newark
Howard, James W., Navy
Howell, Thomas W., 129 N. Maple av., East Orange
Hubach, Maximilian F., Jr., 307 M'tg'mry st., Blmfd.
Hubbard, Robert Y., Hewitt
Huber, William H., 587 Prospect st., Maplewood
Huberman, John, 853 S. 12th st., Newark
Hughes, Lee W., 965 Broad st., Newark
Humphries, Robert E., 637 Central av., East Orange
Hurff, J. Wallace, 671 Broad st., Newark
Hymowitz, Ben, 66 Baldwin av., Newark
Iatesta, Matthew, 9 Wheeler st., West Orange
Ill, Edmund W., 477 Mt. Prospect av., Newark
Ill, Herbert M., 42 Woodland av., Glen Ridge
Inge, Hutchins F., 205 So. Orange av., Newark
Irwin, James R., 330 Washington av., Belleville
Isaac, Benoit C., 83 Central av., Orange
Israeloff, Howard H., 1038 Clinton av., Irvington
Jackson, George H., 2092 Morris av., Union
Jackson, Kenneth K., Army
Jacobs, William, 1030 Stuyvesant av., Irvington
Jaeckle, Charles E., Army
James, Bart M., 31 Lincoln Park, Newark
Janifer, Clarence S., 208 Parker st., Newark
Jarvis, Daniel G., 31 Lincoln Park, Newark
Jaso, James V., 710 Varsity rd., South Orange
Jedel, Meyer, 125 4th st., Newark
Jenkins, R. Jewett, 683 High st., Newark
Jennings, Robert E., 117 Washington st., E. Orange
Jessurun, Samuel H., 613 High st., Newark
Johnson, Robert A., 393 Roseville av., Newark
Jones, Rhys, 33 S. Fullerton av., Montclair
Jonitz, Robert, 153 S. Grove st., East Orange
Judge, John F., 33 Hazelwood av., Newark
Just, Francis, 564 High st., Newark
Kaderabek, Erwin J., 144 Harrison st., East Orange
Kahrs, Grace M., 375 Mt. Prospect av., Newark
Kalb, S. William, 416 Clinton pl., Newark
Kallen, Arnold M., 480 Hawthorne av., Newark
Kalter, George E., 640 Prospect st., Maplewood
Kaney, Emil M., Army
Kaplan, Henry L., 33 Grumman av., Newark
Kaplan, S. Bernard, 31 Lincoln Park, Newark
Katzin, Eugene M., 50 Baldwin av., Newark
Kauder, Warren G., Army
Kaufman, Jerome G., 299 Clinton av., Newark
Kaufman, Michael J., 187 Chancellor av., Newark
Kavanaugh, Daniel E., 566 Mt. Prospect av.,Newark
Kearney, Edward P. J., Army
Keim, William F., Jr., 25 Roseville av., Newark
Keith, Theodore R., 656 Bloomfield av., Nutley
Kelemen, Nicholas M., 315 Central av., East Newark
Kempe, George, 974 Caldwell av., Union
Kennedy, William M., Essex MountainSana.,Verona
Kenney, John A., 39 Madison av., Montclair
Kern, E. Clarence, 45 Park st., Montclair
Kerns, Francis J., 526 W. Market st., Newark
Kessell, John S., Army
Kessler, Henry B., 666 Clinton av., Newark
Kessler, Henry H., 53 Lincoln Park, Newark
Kiessling, Charles E., Army
Kiley, John E., 94 Park st., Montclair
Kimmel, Charles, 488 Broad st., Bloomfield
King, Louis I., 33 N. Oraton Pkwy., East Orange
Kinley, John W., 111 Clinton av., Newark
Kirkby, Cyril S., 45 Woodland av., Glen Ridge
Kirkman, Leroy G., 176 Roseville av., Newark
Kirkwood, Allan S., 53 Union st., Montclair
Klein, Andrew J. V., 73 Lincoln Park, Newark
Klein, Edward C., Jr., 73 Lincoln Park, Newark
Kleinberger, Harry H., 274 Millburn av., Millburn
Kleinman, Maurice, Navy
Klenk, Joseph P., 328 Belleville av., Bloomfield
Kline, George L., Navy
Klosk, Emanuel, 808 S. 12th st., Newark
Kobes, John J., 138 Kearny av., Kearny
Koeck, George P., 625 Mt. Prospect av., Newark
Kohn, Leo, 301 S. Orange av., South Orange
Kolodin, Abraham, 98 Broad st., Bloomfield
Kornfeld, Werner, 645 Central av., East Orange
Kosterlitz, Henry H., 640 Stuyvesant av., Irvington
Kraemer, Manfred, 234 Roseville av., Newark
Kraker, David A., 31 Lincoln Park, Newark
Kralik, Joseph J., 555 Market st., Newark
Krichbaum, Carroll E., Army
Krone, William F., 31 Lincoln Park, Newark
Kruger, William, 31 Lincoln Park, Newark
Kummel, Max, 31 Lincoln Park, Newark
Kunz, Harold G., 15 Highland av., Glen Ridge
Kuperman, Henry L., Army
Lafferty, Elton B., 69 Orange av., Irvington
Landesman, William, 187 Kearny av., Kearny
Lane, Austin W., 98 Prospect st., East Orange
Larkey, Irving G., 95 Shanley av., Newark
Lawless, Edward T., Army
Leaman, Granville M., Army
Le Bel, Louis J. B., 165 Grant av., Nutley
Leber, Otto H., 56 Church st., Montclair
Lee, John J., 309 Park av., Orange
Lee, Robert E., 24 Great Oak drive, Short Hills
Leff, William A., 321 Wyoming av., South Orange
Lefkovics, Sidney C., 41 Clinton pl., Newark
Lehman, David J., Jr., 342 S. Centre st., Orange
Lemkin, Samuel, Army
Levin, Joseph, 831 S. 13th st., Newark
Levin, Murray, 20 Callamore dr., West Orange
Levine, Edward P., Army
Levine, Philip, 35 Elizabeth av., Linden
Levinson, David M., 755 Clinton av., Newark
Levinson, Louis J., 43 S. Pierson rd., Maplewood
Levinson, Robert M., 824 S. 12th st., Newark
Levison, William, Army
Levitt, Jesse N., 26 Clinton pl., Newark
Levy, Anna L., 260 Meeker av., Newark
Levy, Julius, 357 Irving av., South Orange
Lewandowski, Edmund E., 2 Smalley ter., Irvington
Lewis, G. Rae, 458 Washington av., Belleville
Lewis, Leon, Navy
Liccese, Emanuel, 84 Jefferson st., Newark
Licks, Frederick C., Army
Lieb, Saul, 90 Treacy av., Newark
Liegner, Ben, 858 S. 12th st., Newark
Lilien, Bernard B., 88 Norwood st., Newark
Lilien, Milton, 88 Norwood st., Newark
Lincoln, Jennings S., 140 Watchung av.,Up.Montcl'r
Lippman, Harold, 68 Livingston av., Newark
Lipstein, William, 707 Prospect st., Maplewood
Livingston, Bernard, 30 Park av., Caldwell
Livingston, Paul, 299 Main st., East Orange
Loder, Joseph S., 924 S. 17th st., Newark
Loeser, Lewis H., 695 Clinton av., Newark
Lomhoff, Irving I., Army
Long, John F., Kearny av. & Grove st., Kearny
Longo, James J., 74 Ridge rd., N. Arlington
Longshore, Walter E., Jr., 216 Oakwood av., Orange
Lorenze, Edward J., 196 Prospect st., East Orange
Lovell, John F., 1013 Clinton av., Irvington
Lowenstein, Aaron, 860 S. 11th st., Newark
Lowenstein, Harry A., 96 Milford av., Newark
Lowits, Otto, 78 Clinton av., Newark

Lowrey, James H., 79 Congress st., Newark
Luban, Benjamin, 730 High st., Newark
Lundblad, Walter E., 75 Prospect st., East Orange
Luongo, Federico, 212 S. Centre st., Orange
Lupo, Domenico, 763 Broadway, Newark
Lurie, Solomon I., 21 Hillside av., Newark
Lurie, Wolf, 223 E. Fifth st., Plainfield
Lutz, William M., 3 Southern Slope dr., Millburn
Lynch, Albert E. O., 257 Orange road, Montclair
Lynn, Hugh B., Pompton Turnpike, Pompton Plains
Lyons, James V., 333 Park av., Orange
Maas, Max A., 329 Clinton av., Newark
Mabey, J. Corwin, 242 Claremont av., Montclair
Macaluso, Dominic C., 475 Washington av.,Belleville
MacArt, James H., 14 Overhill rd., South Orange
MacArthur, Clymont, 219 Roseville av., Newark
Macdonald, Wentworth S., 1 N. Brookwood dr.,Mtclr.
MacMillan, C. Wright, Navy
Macpherson, Elwood H., 34 Rawley pl., Millburn
Maggio, George A., 419 Roseville av., Newark
Maggio, Nicholas A., 130 Fleming av., Newark
Magovern, Thomas F., 228 S. Orange av., S. Orange
Mahood, Herbert L., 86 Durand rd., Maplewood
Maisel, Irving, 327 Renner av., Newark
Mamlet, Alfred M., 33 Johnson av., Newark
Mancusi-Ungaro, Elviro, 268 Mt. Prospect av.,New'k
Mancusi-Ungaro, Lodovico, 156 Mt. Pr'sp't av.,Nwk.
Manfro, Gerard J., 94 Nassau st., Newark
Marcus, Donald, 987 Sanford av., Irvington
Margolis, Alfred, 736 Sanford av., Newark
Margulies, Charles, 188 High st., Nutley
Marin, Robert B., 85 Park st., Montclair
Marks, Zelda I., 95 Wilson av., Newark
Marquis, Dean W., Navy
Marquis, W. James, 12 Hawthorne av., E. Orange
Marra, Rocco S., 221 Park av., Orange
Martin, William P., 25 Holland rd., South Orange
Masciocchi, Thomas A., 316 Park av., Orange
Mason, Virgil A., 144 Harrison st., East Orange
Massengill, Fulton, 233 Heywood av., Orange
Massey, J. Bruce, 68 W. Market st., Newark
Masterson, John F., 98 Myrtle av., Irvington
Matheke, George A., 592 Park av., East Orange
Matheke, Otto G., 328 Sussex av., Newark
Matheke, Otto G., Jr., Army
Matheson, Gilchrist E., 144 Harrison st., E. Orange
Matthews, Clifford B., 1180 Raymond Blvd., Newark
Matthews, William F., 180 Walnut st., Montclair
Mauer, Richard E., 109 S. Midland av., Arlington
Maurer, K. Virginia, 16 Prospect rd., Livingston
Mautner, Emil, 728 Clinton av., Newark
May, Ernst A., 157 Harrison st., East Orange
McAveney, Thos. F. G., 32 S. Munn av., East Orange
McBride, Hesser G., 254 N. Grove st., East Orange
McCarroll, E. Mae, 59 Hillside pl., Newark
McCauley, Francis J., 140 Roseville av., Newark
McCormick, James E., 775 Elizabeth av., Newark
McCroskery, James H., 396 N. Arl'gt'n av.,E.Orange
McCullough, Walter A., Essex Co. Hosp.,CedarGrove
McGuire, John J., 2 Gould av., Newark
McKeown, Geo. H. C., 68 Montague st.,Br'klyn,N.Y.
McKim, William F., 317 Roseville av., Newark
McLellan, George A., 19 Hawthorne av.,East Orange
McVay, Edward A., 234 Lafayette st., Newark
Medd, John C., 25 Curtis pl., Maplewood
Meehan, Martin M., 339 Washington av., Belleville
Meeker, Irving A., 581 Valley rd., Upper Montclair
Meinhard, Fred, 154 Van Buren st., Newark
Meisel, David B., 818 S. 12th st., Newark
Mellen, Stanley H., 370 Belleville av., Bloomfield
Menk, Paul E., 31 Lincoln Park, Newark
Merkelbach, Walter P., 288 Broad st., Bloomfield
Merliss, Eugene, 386 Clinton av., Newark
Mermod, Camille, 142 Clinton av., Newark
Merrick, Evelina, 142 Clinton av., Newark
Merselis, John G., 110 Irvington av., South Orange
Messina, Thomas, 129 Park av., East Orange
Metsky, Joseph, 777 High st., Newark
Meurlin, Alfred, 144 Harrison st., East Orange
Mick, Edwin C., 46 S. Burnett st., East Orange
Mierau, Ernest W., 1096 Sanford av., Irvington
Miller, Herman P., Army
Miller, I. Irwin, 675 Sanford av., Newark
Miller, Joseph A., 364 Prospect st., South Orange
Miller, Lucille F., 31 Webster pl., Orange
Miller, Nathan, 835 S. 12th st., Newark
Miller, Ralph, 51 Baldwin av., Newark
Miller, Theodore R., Army
Minard, Edwy L., 140 Fourth av., East Orange
Minier, Carl L., Navy
Miningham, William D., 18 Hedden ter., Newark
Minnefor, Charles A., 1164 S. Orange av., S. Orange
Mishell, Daniel R., Army
Mitchell, Augustus J., 59 South st., Newark
Mitchell, Walter L., Jr., 160 Roseville av., Newark
Modeski, Chester J., 73 N. 10th st., Newark
Moeckel, Clarence W., 63 S. Fullerton av., Montclair
Monaco, Dante P., 436 Roseville av., Newark
Monaco, Saverio A., 293 Camden st., Newark
Moncada, Salvatore, 35 Franklin st., Bloomfield
Moore, Dean C., 430 New England ter., Orange
Moore, James A., 530 E. 90th st., N. Y. C.
Moress, Edward J., 1524 Maple av., Hillside
Moretti, John J., Navy
Morgan, Browne, 32 Benson st., Bloomfield
Moss, Mary C., 5 Mountain av., Maplewood
Motzenbecker, Peter F., 680 High st., Newark
Mount, Walter B., 21 Plymouth st., Montclair
Muller, Joseph H., 867 S. 13th st., Newark
Mullin, Eugene F., 500 Sanford av., Newark
Murphy, Thomas W., Jr., Navy
Murray, Harrold A., 624 Mt. Prospect av., Newark
Muta, Samuel A., 47 Park av., West Orange
Nacca, Carl A., 46 Cleveland st., Orange
Nadel, Charles I., 1013 Clinton av., Irvington
Nagler, Benedict, Army
Nappi, Pasquale E., 433 Mt. Prospect av., Newark
Nash, Alexander E., 30 Forrest av., Verona
Nash, Herman S., 865 S. 11th st., Newark
Nataro, Joseph, 192 Littleton av., Newark
Nataro, Maurice, 172 Littleton av., Newark
Nemzek, William P. B., 8 Hedden ter., Arlington
Nevins, William B., Army
Newman, Grace T., 339 Grove st., Montclair
Newman, Julius, 318 Highland av., South Orange
Ney, J. Marshall, 443 Baldwin rd., Maplewood
Nicola, Toufick, 96 Gates av., Montclair
Nimaroff, Meyer, 10 Berkeley ter., Irvington
Noll, Louis, 1383 Clinton av., Irvington
Novich, Max, 262 Schley st., Newark
Nussbaum, Harvey E., 31 Lincoln Park, Newark
Nyiri, William A., 863 S. 12th st., Newark
Oberlander, Gertrude, 866 S. 13th st., Newark
O'Connor, Bernard A., 47 Central av., Newark
O'Connor, Dennis F., 671 Broad st., Newark
O'Connor, Michael J., 98 Shanley av., Newark
O'Connor, Paul A., 157 Roseville av., Newark
O'Crowley, Clarence R., 31 Lincoln Park, Newark
Offenkrantz, Frederick M., 72 Hansbury av.,Newark
O'Grady, Michael J., Navy
Olini, Joseph J., 30 W. Market st., Newark
O'Lini, Louis J., 30 W. Market st., Newark
O'Neill, Charles L., 11 N. Seventh st., Newark
O'Neill, Charles L., Jr., Navy
O'Neill, Gonzalo, Jr., 41 Warwick st., East Orange
Opdyke, Gordon M., 52 Claremont av., Verona
Openchowski, Mieczyslaw, 399 Mt. Pr'sp't av.,New'k
Oransky, Marvin, 534 S. 11th st., Newark

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Ormsby, Thomas J., 1180 Raymond Blvd., Newark
Orris, Harold J., 81 Lyons av., Newark
Orton, Henry B., 224 Delavan av., Newark
Ostrowski, Sigismund J., U.S.P.H.S.
Outwin, Richard N., Army
Paddock, Royce, 965 Broad st., Newark
Palmer, Gideon H., 81 Evergreen pl., East Orange
Palmer, Henry S., 275 Mulberry st., Newark
Panitch, William, 90 Baldwin av., Newark
Pannullo, John N. P., 266 Van Buren st., Newark
Papera, John J., 8 Washington pl., Caldwell
Parell, George C., Army
Parent, Sol, Army
Parker, John E., 385 Park av., Orange
Parkes, Morey, 33 Park av., Caldwell
Parsonnet, Aaron E., 3 Madison av., Newark
Parsonnet, Eugene V., 31 Lincoln Park, Newark
Pascall, Thomas M., 197 Lincoln av., Newark
Pattyson, Ralph A., 144 Harrison st., East Orange
Paul, George A., 788 Lyons av., Irvington
Paul, H. Carl, Navy
Pavia, John R., 48 Mountainview av., East Orange
Payne, Guy, Essex Co. Hosp., Cedar Grove
Payne, Guy, Jr., Navy
Pecora, Samuel, 360 Bloomfield av., Newark
Peer, Lyndon A., 965 Broad st., Newark
Pelliciari, Donald, 965 Broad st., Newark
Pendexter, Sidney E., 11 S. Arlington av., E. Orange
Pennington, Alfred W., 398 N. Maple av., E. Orange
Pentecost, Salvador D., 14 Clarem't av., Maplewood
Perelman, Julius S., 94 Shanley av., Newark
Perham, Bertram S., Army
Perrone, Anthony J., 456 Roseville av., Newark
Petry, William, 109 Treacy av., Newark
Phillips, Algernon A., 212 W. Market st., Newark
Pilch, Arthur G., 1 Willard av., Bloomfield
Pilloni, Louis, 91 Beach st., Bloomfield
Pincus, Isidore, 138 Clinton av., Newark
Pinto, Joseph A., 50 N. 11th st., Newark
Pizzi, Francis W., 15 S. Cedar Parkway, Livingston
Pizzi, Mario V., 205 Park av., Orange
Plant, James S., 51 13th av., Newark
Pois, John, 67 Scotland rd., South Orange
Polaner, George, 417 Clinton pl., Newark
Poller, Frederick K., 681 Stuyvesant av., Irvington
Pollis, Nicholas L., 642 High st., Newark
Polow, Benjamin, Navy
Pomeranz, Raphael, 31 Lincoln Park, Newark
Potter, Raymond T., 144 Harrison st., East Orange
Prestifilippo, Silvestro, 105 Glenridge av., Montclair
Preston, Perry B., 12 Palm st., Newark
Price, Charles W., Essex County Hosp., Cedar Grove
Price, Nathaniel G., 24 Johnson av., Newark
Probst, Everett W., 276 Willow av., Lyndhurst
Proctor, Jesse E., 15 N. 13th st., Newark
Quad, Clifford W., Army
Quinn, Edward D., 323 Belleville av., Bloomfield
Rachlin, Harry T., 987 Sanford av., Irvington
Rados, Andrew, 31 Lincoln Park, Newark
Ram, Nathan H., Army
Ranson, Briscoe B., Jr., 144 Harrison st., E. Orange
Rapalski, Adam J., Army
Rathgeber, Charles F., 18 William st., East Orange
Ravitz, Samuel F., Army
Rawitz, Sidney B., 42 Chancellor av., Newark
Reeve-Allen, Jane, 42 Gordonhurst av., UpperM'tcl'r
Reich, Abraham L., 177 Grove rd., South Orange
Reich, Henry, 31 Lincoln Park, Newark
Reich, Mortimer, 705 Elizabeth av., Newark
Reilly, Christopher J., 331 13th av., Newark
Reilly, John V., 520 Sanford av., Newark
Reinartz, Paul V., Army
Reinfeld, Abraham G., 354 Clinton av., Newark
Reinhardt, Warren I., 276 Springdale av., E. Orange
Reissman, Erwin, 31 Lincoln Park, Newark
Remondelli, Raphael E., 216 Littleton av., Newark
Renzulli, Francesco, 228 S. Seventh st., Newark
RePass, Paul E., Navy
Resch, Henry U., 185 Liberty st., Bloomfield
Restaino, Charles F., 465 Parker st., Newark
Rettig, Isidor L., 36 Milford av., Newark
Revere, Seth D., Army
Ribbans, Robert C., 63 Central av., Newark
Rich, Charles, 191 Littleton av., Newark
Rich, Harry H., 29 Broad st., Newark
Rich, Wallace E., Army
Richardson, Marvin T., Army
Ricketts, Henry E., 25 Shephard av., Newark
Riffin, Irving M., 419 Park st., Upper Montclair
Rigeron, D. George, 160 Willard av., Bloomfield
Riggins, Edwin N., 161 N. Arlington av., E. Orange
Riggs, Vincent J., 334 Springdale av., East Orange
Rinzler, Elliot, 211 Roseville av., Newark
Ripley, E. Warren, 56 Church st., Montclair
Rizzoli, Luigi, 15 Peck av., Newark
Rizzolo, Edward M., 523 Union av., Belleville
Robbin, Lewis, 18 Clinton pl., Newark
Robbins, Charles M., 31 Lincoln Park, Newark
Roberts, Allison H., Navy
Roberts, David C., Navy
Roberts, William A., 11 Park av., Caldwell
Robertson, Euston S., 500 Belgrove dr., Arlington
Robie, Theodore R., 144 Harrison st., East Orange
Robins, David, 24 Commerce st., Newark
Robinson, Louis H., 31 Lincoln Park, Newark
Rocco, Frank, 729 Summer av., Newark
Rogers, Robert H., 49 Ninth av., Newark
Roh, Robert F., Navy
Romano, Patrick J., 310 Central av., Orange
Rommer, Jack J., 25 Ingraham pl., Newark
Rosamilia, Ralph E., 480 N. Seventh st., Newark
Rose, Salvatore J., 242 Ivy court, Orange
Roseman, Herman I., 41 Clark st., Bloomfield
Rosen, Charles D., 115 S. Munn av., East Orange
Rosen, Emanuel, 692 High st., Newark
Rosenbaum, Samuel X., 261 Main st., West Orange
Rosenberg, L. Charles, 11 Murray st., Newark
Rosenberg, Max, 1585 Wyndmoor av., Hillside
Rosenthal, Arnold J., 41 Renner av., Newark
Rosenthal, Oscar J., 54 Van Ness pl., Newark
Rosenthal, Sydney, 35 Wilson av., Newark
Ross, Ira S., 5 Farley av., Newark
Rost, Adolf S., 461 Mountainview av., Orange
Roston, Mark A., 63 Hansbury av., Newark
Roth, Oswald H., 210 Littleton av., Newark
Roth, Samuel R., 31 Lincoln Park, Newark
Rothgesser, Jerome C.,191N.Av'l'n st.,Memphis,Tenn.
Rothhouse, Burnet, 142 Hunterdon st., Newark
Rothschild, Daniel L., Navy
Rothseid, Abraham, 29 Scheerer av., Newark
Rowe, Jack M., 1165 Park av., New York City
Rozsa, Stephen, 837 S. 11th st., Newark
Rubin, Abraham A., 240 Holmes st., Belleville
Ruccia, Arthur, 93 Mt. Prospect av., Newark
Rumage, William T., 513 Sanford av., Newark
Runyan, William J., 106 Broad st., Bloomfield
Russomanno, Raymond L., 227 Clifton av., Newark
Salmon, George G., Jr., 243 Harrison st., E. Orange
Salsberg, Ralph H., 23 Johnson av., Newark
Samson, Norman D., 281 Kearny av., Kearny
Samuel, Jerome H., Army
Santora, Philip J., 361 Roseville av., Newark
Santoro, Thomas A., 321 N. 11th st., Newark
Saporito, Archibald R., 119 Ridge rd., N. Arlington
Saracino, Frank J., 107 Grand pl., Arlington
Saslow, Benjamin I., 102 Shanley av., Newark
Saslow, Stella K., 102 Shanley av., Newark

Savel, Lewis E., 290 Madison av., Irvington
Sax, Max T., Army
Sbarra, Francesco C. N., 189 Roseville av., Newark
Scalera, John F., 28 S. Plainfield av., S. Plainfield
Schaaf, Royal A., 413 Mt. Prospect av., Newark
Schachter, Harry A. H., Navy
Schaefer, Eugene P., 12 Harrison pl., Irvington
Schaffer, Barney, 431 Washington av., Belleville
Schaffer, Nathan, 172 S. Arlington av., East Orange
Schectman, Vera, 385 Osborne ter., Newark
Scheller, George A., 2 Hillside av., Millburn
Scher, Maurice A., 137 Lyons av., Newark
Schiller, Nicholas, 54 Girard pl., Newark
Schmukler, Jacob, 16 Johnson av., Newark
Schneider, Charles A., 694 Clinton av., Newark
Schneider, Leo, 368 Clinton av., Newark
Schneider, Louis, 874 S. 13th st., Newark
Schneider, Richard C., 874 S. 13th st., Newark
Schoenau, Carl W., Bellevue Hosp., New York City
Schotland, Clement E., 31 Lincoln Park, Newark
Schramm, Joseph A., 572 High st., Newark
Schreck, Harry, 192 Roseville av., Newark
Schulsinger, Samuel, 80 Clinton av., Newark
Schulte, Herbert A., 701 Clinton av., Newark
Schults, Anna R., 25 Abington av., Newark
Schurman, Francis H. C., Army
Schwartz, Harold, Navy
Schwartz, Mortimer L., Army
Schwartz, Ralph A., Army
Scott, Harold R., 68 Central av., Orange
Scott, Norman M., 31 Clinton st., Newark
Scranton, Charles W., 59 Washington st., E. Orange
Seidler, Victor B., 16 Plymouth st., Montclair
Seidman, Edwin A., 580 High st., Newark
Seidman, Joshua I., Army
Seifert, Edwin A., 415 Ridgewood av., Glen Ridge
Sellitto, Anthony M., 115 Connett pl., South Orange
Selvaggi, Carlo, 82 Congress st., Newark
Seward, William H., 188 S. Essex av., Orange
Shack, David N., 712 Clinton av., Newark
Shack, Maxwell H., 19 Lyons av., Newark
Shaner, Ralph D., 94 Hillside av., Nutley
Shannon, James B., 66 S. Fullerton av., Montclair
Shannon, Lardner M., 66 S. Fullerton av., Montclair
Shapiro, Louis, 146 Broad st., Newark
Shapiro, Ralph N., 1 Scotland road, South Orange
Shapiro, Samuel A., Army
Shaul, Frederick G., 10 Washington st., Bloomfield
Shaul, John F., Navy
Shaw, John J., 333 Beech Spring rd., South Orange
Shaw, Ned, Army
Shechner, Isadore, 244 Broadway, Newark
Sheehan, Daniel C., Army
Sherman, A. Russell, 671 Broad st., Newark
Sherman, Arthur E., Army
Sherman, Elbert S., 671 Broad st., Newark
Shill, Benjamin, 31 Lincoln Park, Newark
Shlionsky, Herman, Army
Shor, David M., 32 S. Munn av., East Orange
Shreehan, Hubert F., Navy
Shulman, Murray W., 913 S. 20th st., Newark
Siegel, Jack G., 38 Johnson av., Newark
Siegel, Jacob W., 96 S. 10th st., Newark
Sieskind, Richard S., 1157 Clinton av., Irvington
Silberner, Herbert B., 81 Godwin av., Newark
Silver, Harry B., 190 Clinton av., Newark
Silverman, S. Andrew, 653 S. 18th st., Newark
Silverstein, Benj. J., 32 Hillside av., Newark
Silversteln, Jacob M., 73 Main st., Millburn
Simmons, Albert V., 720 Prospect st., Maplewood
Simms, George F., 541 Page av., Lyndhurst
Simon, Henry, Army
Simon, Ludwig L., 199 Keer av., Newark
Simonson, Louis, 202 Osborne ter., Newark
Singer, Max, 147 Johnson av., Newark
Sisson, Nelson W., 144 Harrison st., East Ornage
Sivolella, Nicholas W., 245 Clifton av., Newark
Skwirsky, Joseph, 170 Hawthorne av., Newark
Slavin, Paul, 31 Lincoln Park, Newark
Smalley, Sara D., 530 Clifton av., Newark
Smalzried, Elmer W., Navy
Smarzo, Marjorie M., 46 Vernon ter., East Orange
Smith, Byron J., 1041 S. Orange av., Newark
Smith, Charles H., 270 Ridgewood av., Glen Ridge
Smith, Christopher A., 295 Montg'm'ry st., Bloomf'd
Smith, Ellis L., Essex Co. Isolation Hosp., Belleville
Smith, Harold W., 179 Lincoln av., Orange
Smith, Henry G., Essex Co. Hosp., Cedar Grove
Smith, Joseph J., 325 13th av., Newark
Smith, Leonard H., 32 Washington st., East Orange
Smith, Thayer A., Forest dr., Short Hills
Snavely, Earl H., Newark City Hospital, Newark
Snook, Lee O., Jr., 8 Hedden ter., N. Arlington
Sobin, Julius, 24 Waverly av., Newark
Solk, Arthur G., 88 Clinton av., Newark
Solomon, Harold, 79 Shanley av., Newark
Somers, Fred L., 144 Harrison st., East Orange
Sonnenberg, Arthur, 74 Treacy av., Newark
Sorock, Emil M., 1405 Shenand'h st.,LosAngeles,Cal.
Soschin, Samuel J., 31 Lincoln Park, Newark
Spallone, Joseph C., 123 Mt. Prospect av., Newark
Sperling, Irving L., 62 Lyons av., Newark
Spinner, Samuel L., 15 Third st., Elizabeth
Sprague, Edward W., 86 Washington st., Newark
Staehle, Richard H., 34 Lyons av., Newark
Stahl, Alfred, 55 Lincoln Park, Newark
Stahl, Charles, 659 Sanford av., Newark
Staknevich, John H., 658 Grove st., Irvington
Starr, George R., Jr., 665 Berkeley av., Orange
Statman, Arthur J., 17 Leslie st., Newark
Stearns, Thornton, 312 Harrison st., East Orange
Steiner, Edwin, 31 Lincoln Park, Newark
Steiner, Herbert, 350 Stuyvesant av., Irvington
Stern, David A., 127 Lyons av., Newark
Stern, Max E., 2 Milford av., Newark
Stern, Morton M., 24 Girard pl., Newark
Stevens, Merton H., 58 S. Maple av., East Orange
Stewart, Robert G., 79 Midland av., Montclair
Stickles, Lloyd C., 49 Parkhurst st., Newark
Stiles, C. Campbell, 713 Park av., East Orange
Stoddard, Gordon V., Army
Stokes, Donald E., 120 Prospect st., South Orange
Stoll, George F., 330 Washington av., Belleville
Strack, Jerome A., 286 Charlton av., South Orange
Strack, Vincent J., 1072 S. Orange av., Newark
Straub, Herbert H., 242 Springdale av., East Orange
Straus, Max, 87 Harrison pl., Irvington
Strauss, Frederick, Army
Strauss, Max, 190 Clinton av., Newark
Strauss, William T., Jr., 6 Jerome pl., UpperMontcl'r
Streen, Morris E., 908 Bergen st., Newark
Sturchio, Edoardo, 104 Ferry st., Newark
Sturchio, Eugenio, 178 Mt. Prospect av., Newark
Suesserman, Henry, 389 Lyons av., Newark
Sullivan, William T., Navy
Sutton, Harold L., Army
Sutton, Joseph G., Essex Co. Hosp., Cedar Grove
Swain, Richard D., Jr., 211 Roseville av., Newark
Symes, Earl R., 544 Belgrove drive, Kearny
Szerlip, Leopold, 31 Lincoln Park, Newark
Szivos, Louis A., 160 Glenwood av., East Orange
Taff, Harry, 478 Orange st., Newark
Taffet, William, 379 Union av., Belleville
Tansey, W. Austin, Jr., Army
Tarbell, Harold A., 13 Pennington st., Newark
Teeter, Charles E., 418 Orange st., Newark
Tenney, Albert S., 6 N. Munn av., East Orange
Tepper, Victor, 2 Parkview ter., Newark

Thomas, John H., Navy
Thomison, Harry E., 605 Broad st., Newark
Thompson, Arthur F., 314 Oakwood av., Orange
Thompson, Austin B., 479 Highland av., Orange
Thomson, Carroll S., Fair Oaks Sana., Summit
Thornhill, Arthur C., 47 Forest st., Montclair
Thornley, William F., 495 Prospect st., Maplewood
Tillis, Herman H., 31 Lincoln Park, Newark
Tilton, William R., 763 Broad st., Newark
Tirrell, C. Malcolm, Navy
Tobey, Franklin J., 11 Hazelwood av., Newark
Tobey, John R., 11 Hazelwood av., Newark
Toczek, Heinrich A., 391 Bergen st., Newark
Tomec, Richard F., 42 Melrose pl., Montclair
Torppey, John J., 472 Sanford av., Newark
Trautwein, Charles F., 131 Nesbit ter., Irvington
Troedsson, Bror S., 188 S. Essex av., Orange
Tuly, Ralph, Navy
Tunis, Benno B., 22 Ingraham pl., Newark
Turi, Amedeo E., 57 Garside st., Newark
Turner, Charles F., 151 Grove st., Montclair
Tushnet, Leonard, 662 18th av., Irvington
Tutela, Arthur C., 220 S. Seventh st., Newark
Tutschulte, Ernest, 111 Mt. Pleasant av., Newark
Twitchell, Adelbert B., 162 S. Orange av., S. Orange
Tymeson, Walter R., 310 Main st., Orange
Ulan, Oscar, 92 Fleming av., Newark
Ulvestad, Lawrence E., 147 Halsted st., East Orange
Urbach, George, 181 Chancellor av., Newark
Valentin, Irmgard, 131 Harrison st., East Orange
Vallario, Frank A., 333 Clifton av., Newark
Vander Veer, H. Garrett, 295 M'tgomery st., Bl'mf'd
Van Emburgh, George H., 575 Belgrove dr.,Arlingt'n
Van Gieson, Edward J., Navy
Vannatta, George W., 226 N. Park st., East Orange
Van Ness, H. Roy, 444 Parker st., Newark
Verbeck, Geo. B., 20 Church av., Ballston Spa, N. Y.
Villanova, Ralph N., 266 S. Eighth st., Newark
Vincent, Nicholas F., 144 Harrison st., E. Orange
Virgilio, Anthony A., 87 S. Centre st., Orange
VonHofe, Frederick H., 75 Prospect st., E. Orange
Voorhees, Florence E., 140 Roseville av., Newark
Wagner, John, 48 Wilson av., Newark
Wakeley, William E., 144 Harrison st., East Orange
Waldron, Robert E., Army
Walkenberg, Michael, 56 Clinton pl., Newark
Wallack, Charles A., 23 Treacy av., Newark
Walsh, Charles R., 95 W. Northfield av., Livingston
Walton, Ralph W., 102 Gates av., Montclair
Wambsganss, Magdalena, 44 Devine st., Newark
Wangner, William F., 1190 Broad st., Bloomfield
Ward, Elisabeth B., 112 Chancellor av., Newark
Ward, Gertrude P., 41 Park pl., Bloomfield
Ward, William R., 112 Chancellor av., Newark
Ward, William R., Jr., Army
Warner, Halsey F., 444 Central av., East Orange
Warner, William H. A., 444 Central av., EastOrange
Washington, William H., 321 High st., Newark
Waterman, Samuel M., 41 Shanley av., Newark
Weber, Francis C., 286 Mt. Prospect av., Newark
Weeks, Norman E., 159 Christopher st., Montclair
Weinmann, Max H., 714 Scotland rd., Orange
Weinstein, Francis S., 857 S. 11th st., Newark
Weinstein, Leopold, 82 Lyons av., Newark
Weinstein, Morris W., 942 Sanford av., Irvington
Weinstock, Michael B., 33 Johnson av., Newark
Weiss, Louis, 519 Springfield av., Newark
Weiss, Mortimer H., Army
Weiss, Selma, 2 Stratford pl., Newark
Welkind, Allen A., 365 Osborne ter., Newark
Weller, Arthur, 19 Hillyer st., Orange
Wesson, Harrison R., Navy
Weston, Clifford G., 27 Woodland av., Glen Ridge
Wheeler, William K., Navy
Whelan, Edward P., 460 Franklin av., Nutley
White, Robert R., 144 Harrison st., East Orange
Wiener, David, 196 Weequahic av., Newark
Willan, Edward H., 74 S. Munn av., East Orange
Willey, F. Parker, 153 Roseville av., Newark
Williams, John J., 88 Walnut st., Newark
Willner, Irving, 18 Waverly av., Newark
Willner, Philip, 852 S. 11th st., Newark
Willson, James H., 144 Harrison st., East Orange
Wilson, John H., Jr., 85 Halsted st., East Orange
Winter, Egon W., 825 S. 10th st., Newark
Wolf, Raymond E., 251 Ridgewood av., Glen Ridge
Wolfe, Jacob S., 44 Watsessing av., Bloomfield
Wolfe, William W., 383 Mulberry st., Newark
Wood, E. LeRoy, 225 Ballantine Pkwy., Newark
Woolf, Bernhardt H., 41 Hedden ter., Newark
Work, John L., Mountainside Hosp., Montclair
Wort, Frederick J., 1080 Broad st., Newark
Wrensch, Alexander E., 79 Valley rd., Montclair
Wright, Robert E., 55 S. Clinton st., East Orange
Wuerthele, Virginia E., 560 Mt. Prospect av.,Newark
Wujciak, Henry J., Navy
Wurts, Margaret M., 27 Wellesley av., Up. Montclair
Wurzel, Milton, Army
Wyatt, Joseph H., 135 Clinton av., Newark
Wyker, Arthur W., 57 Park pl., Bloomfield
Wynder, Alfred, 654 Lyons av., Irvington
Yablonsky, Max, 30 Shanley av., Newark
Yadkowsky, Emanuel, 637 High st., Newark
Yaguda, Asher, 31 Lincoln Park, Newark
Yankowicz, Michael, Army
Yates, Glen L., 270 Ridgewood av., Glen Ridge
Yelin, Gabriel, Army
Yoskalka, Jack S., 136 Renner av., Newark
Young, I. Henry, 220 Columbia av., Irvington
Young, John H., 37 N. Fullerton av., Montclair
Zacher, Andrew A., 685 High st., Newark
Zager, Saul, 31 Lincoln Park, Newark
Zehnder, A. Charles, 188 Roseville av., Newark
Zimmer, William, Army
Zimmerman, Coler, 6 Colony dr., S., West Orange
Zingali, John A., 105 Glenridge av., Montclair
Zvaifler, Nathan, 46 Wilbur av., Newark
Zweibel, Leonard, 871 S. 11th st., Newark
Zweigel, Isidore, 22 Monticello av., Newark
Zybulewski, Edmund A., 410 Bergen st., Newark

Number of Active Members and basis of representation, 1232.

ASSOCIATE MEMBERS

Adalson, Edward, 201 Keer av., Newark
Alexander, John W., 227 Main st., Orange
Amato, John R., 59 South st., Newark
Autorino, Ralph R., 10 Harrison av., Montclair
Block, Charles, Army
Boyd, James W., 67 S. Munn av., East Orange
Brady, Frank J., 1038 S. Orange av., Newark
Brandchaft, Bernard, 658 Springfield av., Newark
Cassio, William L., 58 Jones st., Newark
Cincotti, Victor, 11 Hill st., Newark
Cooper, Jehu P., Army
Drewery, Robert E., E. Orange Gen. Hosp.,E.Orange
Edelson, Edmond, 127 Lehigh av., Newark
Firtel, Saul I., 764 Scotland rd., South Orange
Goldberg, Bernard R., 31 Lincoln Park, Newark
Hillman, Ernest C., Jr., 15 Washington st., Newark
Iannone, Angelo B., 210 Watchung av., Orange
Israel, Joseph, 252 Washington av., Belleville

Kearney, Paul A., Army
Kimche, Irwin, 27 Rawley pl., Millburn
Koch, James, Army
Lieb, Robert L., 865 S. 18th st., Newark
Linz, Curt, 431 Franklin av., Nutley
Lohman, Herman, 91 Spruce st., Newark
Lombardo, Bartlo, 111 Wilson av., Newark
Mancusi-Ungaro, Harold, Army
Mele, Vincent, 275 S. Seventh st., Newark
Merk, Anthony, 79 N. Ninth st., Newark
Morton, Thomas V., Jr., 48 Willard av., Bloomfield
Rosenberg, Lillian M., 334 Bloomfield av., Montclair
Russomanno, Paul, 212 Clifton av., Newark
Scudese, Vincent A., 144 Ridge st., Newark
Siwek, Stanley, 331 Cleveland av., Harrison
Sobol, Herman, 626 Highland av., Newark
Willner, Albert, Army

GLOUCESTER COUNTY (8)

Society organized December, 1818. Regular meetings on third Thursday of each month, except June, July and August. Annual Meeting in May. Annual Social Session in October.

ACTIVE MEMBERS

Black, Maskell B., 128 E. High st., Glassboro
Booth, George R., 219 Highland av., Westville
Bowersox, Clarence A., 509 N. Broad st., Woodbury
Brewer, David R., Jr., 112 N. Broad st., Woodbury
Broselow, Benjamin G., Delsea drive., Franklinville
Burkett, J. Paul, 215 Delaware st., Woodbury
Burkett, Wendell J., 16 W. Holly av., Pitman
Campo, A. Guy, 401 Broadway, Westville
Carpenter, William H., 39 Aberdeen pl., Woodbury
Chalfant, William P., Br'dway & Crafton av.,Pitman
Collins, Louis K., 54 State st., Glassboro
Davis, Clarence E., S. Academy st., R.D. 1, Glassb'ro
Diverty, Henry B., 38 Cooper st., Woodbury
Faux, Frederick J., 32 N. Columbia st., Woodbury
Fisler, Charles F., 140 Maple st., Clayton
Fooder, Horace M., 110 Main st., Williamstown
Gillis, Alfred G., 19 W. Maple st., Clayton
Hollinshed, Ralph K., 351 Broadway, Westville
Hughes, Joseph F., 228 S. Evergreen av., Woodbury
Husik, Franklin B., 101 S. Main st., Glassboro
Livengood, Baxter A., 64 Cooper st., Woodbury
McGuire, William A., 29 W. Wash'gton st.,Paulsboro
Moore, Ralph L., 127 N. Broad st., Woodbury
Patterson, Isaac N., 230 Broadway, Westville
Pedrick, William W., 11 West st., Glassboro
Pegau, Paul M., 246 Briar Hill lane, Woodbury
Rhoads, S. Creadick, 104 Station av., Westville
Rogers, Dorothy M., 50 Cooper st., Woodbury
Ruttenberg, Louis, 19 Hopkins st., Woodbury
Serri, William S., 447 Kings Highway, Swedesboro
Sheets, Cecil C., 213 W. Broad st., Paulsboro
Sherman, Fuller G., 204 Delaware st., Woodbury
Sinexon, Henry L., 36 W. Broad st., Paulsboro
Sirotta, E. Bernard, Army
Sooy, L. Thomas, 202 W. Holly av., Pitman
Stewart, Irving J., 529 Kings Highway, Swedesboro
Ulmer, Chester I., 431 W. Broad st., Gibbstown
Underwood, J. Harris, 509 N. Broad st., Woodbury
Venturo, Ralph C., Hunter st., Woodbury
Wandall, Frederick G., 50 E. High st., Clayton
Weems, Don B., 105 E. Mantua av., Wenonah
Wentzell, J. Earl, 5 E. Mantua av., Wenonah
Whitaker, Henry J., Army
Wright, Herman W., 818 S. Broadway, Pitman
Zapf, Reville D., 100 W. Mantua av., Wenonah

Number of Active Members and basis of representation, 45.

HUDSON COUNTY (9)

Society organized October 11, 1851. Meets first Tuesday evening of each month, October to May, inclusive. If a legal holiday, meeting to be held on next day. Annual Meeting in May.

ACTIVE MEMBERS

Africano, Julius V., 43 Columbia ter., Weehawken
Agolia, Michael W., 2201 Palisade av., Union City
Ainsley, H. Bryson, 246 Union st., Jersey City
Alpert, Edward, 661 Jersey av., Jersey City
Alter, Nicholas M., 410 Fairmount av., Jersey City
Amdur, Louis A., 2540 Boulevard, Jersey City
Angelo, Joseph A., Army
Annitto, John E., 170 Belmont av., Jersey City
Anrig, Grace E., 613 Summit av., Union City
Arbeit, Sidney R., Army
Arena, John, 9209 Boulevard, North Bergen
Aria, Charles J., Army
Aria, Michael H., 31 Glenwood av., Jersey City
Arndt, Frank R., 7500 Bergenline av., North Bergen
Aronowitz, Harry T., 923 Avenue C, Bayonne
Artaserse, George V., 185 Bergen av., Jersey City
Ash, Arthur F., 710 Boulevard, E., Weehawken
Auriemma, Michele, 419 Adams st., Hoboken
Bahnson, Conrad M., 170 Bowers, Jersey City
Bailyn, Emanuel, 400 60th st., West New York
Ballinger, Reeve L., 659 Kearny av., Arlington
Balsamo, Anthony J., 5016 Hudson av., W.NewYork
Barbarito, William N., 135 Bentley av., Jersey City
Barone, Francis A., Army
Bedrick, John J., 945 Avenue C, Bayonne
Ben-Asher, Solomon, 61 Gifford av., Jersey City
Benjamin, Harold C., 59 Crescent av., Jersey City
Berlin, Joseph I., 2600 Boulevard, Jersey City
Betcher, Albert M., 317 Fairmount av., Jersey City
Biglianl, Urban R., 606 80th st., North Bergen
Blakey, Abram P., 157 Wegman Pkwy., Jersey City
Blum, Milton, Army
Bookrajian, Edward N., 8027 Boulevard, N. Bergen
Borrone, Milton G., 2624 Boulevard, Jersey City
Borshaw, Hyman, Navy
Bortone, Frank, 2765 Boulevard, Jersey City
Boselli, Emile H., 614 15th st., Union City
Bottl, John A., 236 Summit av., Jersey City

Boyers, Sidney S., 43 Clifton ter., Weehawken
Boyle, Francis L., Navy
Bradasch, George A., Army
Brady, Thomas S., 678 Avenue C, Bayonne
Braitman, Max, 412 60th st., West New York
Brauer, Selig L., 2012 Boulevard, Jersey City
Braunstein, Sigmund C., 424 57th st., W. New York
Braunstein, William P., 1 Bellevue st., Weehawken
Brennock, Thomas McG., 3 Webster av., Jersey City
Bresev, Morris, Army
Brick, George J., 43 Cottage st., Jersey City
Brignola, Gerald C., 634 Bloomfield st., Hoboken
Brophy, Francis X., 55 Gifford av., Jersey City
Brozdowski, John J., 554½ Jersey av., Jersey City
Butler, Vincent P., 33 Bentley av., Jersey City
Campana, Vincent R., 386 Fairm'nt av., Jersey City
Cangemi, Vito F., 50 Glenwood av., Jersey City
Cannon, Edward A., 7512 Boulevard, North Bergen
Caridi, Salvatore, 431 59th st., West New York
Chayes, Sydney, 980 Avenue C, Bayonne
Choffy, Sylvester A., 202 Bergen av., Jersey City
Christian, Henry A., Army
Cohen, Herman N., 108 13th st., Hoboken
Cohen, Samuel, Army
Cohen, Samuel A., Army
Comora, Herman C., 317 60th st., West New York
Connell, Emmet J., 2227 Boulevard, Jersey City
Conty, Anthony J., 318 48th st., Union City
Corless, Joseph F., 5503 Palisade av., Jersey City
Cosgrove, Robert A., 277 Harrison av., Jersey City
Cosgrove, Samuel A., 88 Clifton pl., Jersey City
Coughlin, John P., 160 Wegman Parkway, JerseyC'y
Cowan, Joseph H., Army
Cracco, Frederick A., 211 Pasilade av., Union City
Cricco, Carl F., 1201 Park av., Hoboken
Culver, S. Herbert, 75 Magnolia av., Jersey City
Cupainoli, Richard A., Navy
Cziraky, Anton, 516 34th st., Union City
D'Acierno, Pellegrino A., 1708 Palisade av., UnionC'y
Danielson, John J., Army
Davis, Daniel, Army
DeFuccio, Charles P., 12 Duncan av., Jersey City
DeFusco, G. Thomas, Army
Deitmaring, Francis A., 7922 Boulevard, N. Bergen
Del Baglivo, Mario, Army
DeMarco, Silverino V., 2554 Boulevard, Jersey City
Detrano, Salvatore J., 903 Washington st., Hoboken
DeVincenzo, F. Richard, 629 Wash'gton st.,Hobok'n
Dexter, Harriet E. T., 903 Avenue C, Bayonne
Donohoe, Lucius F., 33 Dodge st., Bayonne
Donohue, Daniel J., 139 Highland av., Jersey City
Doran, Ralph J., 200 11th st., Hoboken
Doran, William G., 2685 Boulevard, Jersey City
Dougherty, Daniel D., Army
Doyle, John J., 426 Fairmount av., Jersey City
Driscoll, Raymond S., Army
Dukes, Howard R., 220 Kearny av., Kearny
Edwards, Lena F., 358 Pacific av., Jersey City
Elsasser, Theodore H., 7206 Park av., Woodcliff
Elwood, Benjamin J., 810 Boulevard, Bayonne
Enright, James G., 25 Kensington av., Jersey City
Ettinger, Samuel, 501 32nd st., Union City
Evans, J. Lawrence, 7117 Park av., Woodcliff
Faber, Edward, Army
Fabriele, John B. ,1112 Boulevard, Bayonne
Facciolo, Frank, 562 Boulevard, Bayonne
Faison, John B., 45 Glenwood av., Jersey City
Fattel, Henry C., 8300 Boulevard, North Bergen
Federer, John J., 69 Columbia ter., Weehawken
Feinberg, Harry, 807 Avenue A, Bayonne
Feller, William, Army
Fenimore, Edward D., Army
Fialk, Harry, Army
Ficke, Sylvia A., 884 Summit av., Jersey City
Fifer, William T., 746 Avenue C, Bayonne
Figurelli, Francis A., 88 Highland av., Jersey City
Finger, Frederick A., 943 Avenue C, Bayonne
Finke, Charles H., 317 York st., Jersey City
Finn, Henry R. W., 84 Lembeck av., Jersey City
Flicker, David J., Army
Frank, Herman I., Army
Frank, Morris, 920 Avenue C, Bayonne
Frank, Nathan, Army
Franklin, I. Harold, 191 Palisade av., Jersey City
Freyberger, George A., Army
Freymann, Walter, 5006 Hudson av., W. New York
Furman, Sol T., 344 Fairmount av., Jersey City
Garbarini, John G., 907 Summit av., Jersey City
Garibaldi, Louis J., 1018 Hudson st., Hoboken
Gerne, Timothy A., 972 Summit av., Jersey City
Gerner, Harry E., 27B Garden ter., North Arlington
Ghee, Euclid P., 115 Claremont av., Jersey City
Ginsberg, George, 624 Bloomfield st., Hoboken
Gleason, Thomas P., Army
Goldman, David L., 42 W. 22nd st., Bayonne
Goldsmith, Alfred S., Navy
Goldstein, Joseph D., 2801 Boulevard, Jersey City
Goldstone, Karl H., 16 62nd st., West New York
Good, Richard, 4619 Park av., Union City
Goodrich, Stewart L., 812 Avenue C, Bayonne
Gordon, Isaac L., 1815 Boulevard, Jersey City
Gorenberg, Harold, Navy
Granelli, Humbert A., 213 Garden st., Hoboken
Greenberg, Philip, 1919 Boulevard, Jersey City
Greenberg, Solomon, 52 Avenue B, Bayonne
Greene, Albert D., 915 Palisade av., Union City
Greene, Harry, 90 Duncan av., Jersey City
Grieco, Emil H., Army
Grossman, Morris, 921 Bergen av., Jersey City
Grossman, Rubin, Army
Grubowski, Joseph N., 562½ Jersey av., Jersey City
Gurley, Katharine A., 2671 Boulevard, Jersey City
Gutmann, Erwin K., Army
Hall, Perry O., 2553 Boulevard, Jersey City
Halligan, Earl J., 254 Montgomery st., Jersey City
Halligan, Harold J., 254 Montgomery st., Jersey City
Halperin, David, 590 Bergen av., Jersey City
Handler, Harry, 305 York st., Jersey City
Harter, Louis F., 174 Bowers st., Jersey City
Hartwell, H. Ameroy, 777 Boulevard, E., Weeh'wk'n
Harvey, John W., 818 Avenue C, Bayonne
Harz, William V., Army
Hasking, Arthur P., 318 Montgomery st., Jersey City
Hauptman, Harry, Navy
Heilbrunn, Julius, 2540 Boulevard, Jersey City
Hekimian, Jacob H., 2314 Palisade av., Weehawken
Hernandez, Manuel, 1974 Boulevard, Jersey City
Herradora, Juan R., 2750 Boulevard, Jersey City
Higgins, Gerald L., 86 Bartholdi av., Jersey City
Higgins, John T., 145 Highland av., Jersey City
Hillel, Joseph, Army
Hirsch, Solomon, 109 Van Wagenen av., Jersey City
Holland, Moses H., 2412 Palisade av., Weehawken
Hollywood, James L., 219 Danforth av., Jersey City
Howeth, John L., Navy
Huss, Louis, 4313 Bergenline av., Union City
Imhoff, John G., 913 Summit av., Jersey City
Introcaso, Dominick A., 45 Crescent av., Jersey City
Irving, Henry C., Army
Ishkhanian, Nouri I., 6032 Palisade av., W. New Y'k
Jacks, Oscar, 476 Mercer st., Jersey City
Jaffe, Benjamin, Army
Jaffe, Herman M., 2600 Boulevard, Jersey City
Jaffin, Abraham E., 41 Emory st., Jersey City
Jaques, J. Eugenia, 74 Waverly st., Jersey City
Jentz, John H., 67 Sherman pl., Jersey City
Johnson, Archie W., 169 Claremont av., Jersey City
Jones, Clement M., 454 Boulevard, Bayonne

Jones, J. Morgan, Valley rd., R. F. D., Oakland
Joseph, Benjamin M., 2771 Blvd., Jersey City
Judy, Kenneth H., 26 Journal Square, Jersey City
Justin, Arthur W., 41 Fulton st., Weehawken
Kainer, Herbert, 12 Liberty pl., Weehawken
Kaplan, Herman B., 324 44th st., Union City
Katz, Jacob D., 38 Bentley av., Jersey City
Katz, Sidney, Army
Kearney, John V., 335 78th st., North Bergen
Keegan, Thomas D., 8 Gifford av., Jersey City
Keeney, James C., Army
Kelly, Bernard S., 1954 Boulevard, Jersey City
Kelly, Harry R. J., Army
Kennedy, John W., 414 61st st., West New York
Kiely, Eugene M., 800 Hudson st., Hoboken
Kimmel, M. Leonard, Army
Klein, Alfred, 501 32nd st., Union City
Klein, Julius, 1513 Palisade av., Union City
Kolb, John M., 1611 Boulevard, North Bergen
Kooperman, Barnett, 321 60th st., West New York
Kooperstein, Samuel I., Army
Kornfield, Norman B., 24 Clinton av., Arlington
Kosminsky, Louis, 321 60th st., West New York
Kraemer, Samuel H., 309 Baldwin av., Jersey City
Kraut, Arthur M., 25 Gifford av., Jersey City
Kresch, Philip, 86 W. 34th st., Bayonne
Kruger, Alfred L., Army
Kuhlmann, Alvin E., 527 37th st., Union City
Kun, Bertram, 135 Belmont av., Jersey City
Lakiszak, Roman T., 175 Jackson av., Jersey City
Landshof, Charles A., Army
Lane, Thomas F., Army
Lange, Louis C., 50 Clifton ter., Weehawken
Lawsing, G. Conde, 443 66th st., West New York
Lee, William A., 447 West Side av., Jersey City
Lefkowitz, Jacob H., 445 64th st., West New York
Leining, Albert, 45 48th st., Weehawken
Leir, J. Krevin, 2787 Boulevard, Jersey City
Lempke, Richard J., 3 Armstrong av., Jersey City
Lepis, A. Albert, 89 Danforth av., Jersey City
Levine, G. Irving, Army
Linden, Mortimer H., 45 Clendenny av., Jersey City
Lindroth, Lawrence V., 4633 Boulevard, N. Bergen
Lipshutz, Benjamin, 18 West 22nd st., Bayonne
Lipshutz, Charles, 804 Avenue C, Bayonne
Lisanti, Gaetano, 6109 Monroe pl., West New York
Lobban, Robert B., 2595 Boulevard, Jersey City
Londrigan, Joseph F., 832 Bloomfield st., Hoboken
Londrigan, Joseph F., II, 832 Bloomfield st.,Hoboken
Long, Miles T., 2150 Boulevard, Jersey City
Luczynski, Edward W., 726 Avenue C, Bayonne
Lupin, Edward E., 930 Boulevard, Bayonne
Lynch, Roland J., Mental Diseases Hosp., Secaucus
Lynn, Irving I., Army
Macchia, Benjamin J., 358 Arlington av., Jersey City
Machkowsky, Edwin, 241 Second st., Jersey City
Mackin, John J., 596 Bergen av., Jersey City
Madaras, John S., 870 Avenue C, Bayonne
Madison, L. Keith, 358 Pacific av., Jersey City
Manette, Milton, 535 41st st., Union City
Mangone, Edith, 174 Clinton av., Jersey City
Mangone, George F., 811 Palisade av., Union City
Marcus, Kurt, 85 Bowers st., Jersey City
Markowitz, Irwin B., 2157 Boulevard, Jersey City
Marrella, Louis F., 101 Lafayette st., Jersey City
Marshall, Frank A., 2202 Pallsade av., Weehawken
Mastromonaco, Joseph D., 790 Avenue C, Bayonne
Mathesheimer, Jacob L., 280 Old Bergen rd., Jer.C'y
Mathews, William J., 938 Hudson st., Hoboken
Maturi, Vincenzo E., 814 Boulevard, Bayonne
Maver, William W., 532 Bergen av., Jersey City
McCarron, James A., 341 Avenue A, Bayonne
McCarthy, John J., 1001 79th st., North Bergen
McLean, Hugh A., 414 61st st., West New York
McLoughlin, Frank J., 558 Jersey av., Jersey City
McLoughlin, John W., 34 W. 32nd st., Bayonne
McNenney, Claudio E., 113 Fairview av., Jersey City
Meehan, George E., 117 Mercer st., Jersey City
Meltsner, Louis, 904 Hudson st., Hoboken
Meltzer, Louis, Army
Mersheimer, Christian H., 15 Reservoir av.,JerseyC'y
Meyer, William, 2128 New York av., Union City
Meyerson, Noah, 428 59th st., West New York
Mickewich, Stephen A., Army
Miller, Robert B., Navy
Mintz, Alvin R., Army
Miranti, Paul J., 2685 Boulevard, Jersey City
Modarelli, Walter H., 1505 Central av., Union Ctiy
Monfort, Robert N., 650 Bergen av., Jersey City
Monica, Louis A., 653 Avenue C, Bayonne
Morganstein, Louis K., 813 Avenue C, Bayonne
Moriarty, John F., 723 Washington st., Hoboken
Morley, Grace C., 64 Clifton ter., Weehawken
Muccia, John J., Army
Mueller, George H., 102 Summit av., Jersey City
Mulvihill, William J., 275 Boulevard, Bayonne
Murphy, James M., 2757 Boulevard, Jersey City
Murray, Joseph A., 765 Avenue C, Bayonne
Mustermann, Otto H., 303 48th st., Union City
Muttart, George W., 2521 Boulevard, Jersey City
Mutter, Alfred A., 75 Beech st., Arlington
Nafash, Shafeek, Army
Nicholson, Frank P., 895 Summit av., Jersey City
Nobile, James J., Army
Norton, James F., 58 Kensington av., Jersey City
Norwich, Louis E., 355 Avenue C, Bayonne
Nuse, Edward F., 550½ Jersey av., Jersey City
Ockene, Abraham, 2415 Palisade av., Union City
O'Connor, John J., 2124 New York av., Union City
Olpp, Arch. E., 1516 Bergenline av., Union City
Ortolano, James J., Army
O'Shea, John J., 2200 Palisade av., Weehawken
Oshrin, Henry, Army
O'Sullivan, John R., 11 Quincy av., Arlington
Pagliughi, John J., 1915 Palisade av., Union City
Pearlstein, Frank, 325 60th st., West New York
Peckman, Abram, 2511 Boulevard, Jersey City
Penchansky, Samuel J., 847 Avenue C, Bayonne
Perkel, Louis L., 2801 Boulevard, Jersey City
Perlberg, Harry J., 921 Bergen av., Jersey City
Perrone, Arthur F., 415 60th st., West New York
Peters, Menelaus, 921 Bergen av., Jersey City
Peterson, Charles A., 921 Washington st., Hoboken
Piltz, George F., 153 69th st., Guttenberg
Pindar, Frederick S., 7500 Park av., Woodcliff
Piskorski, Abdon V., 604 Jersey av., Jersey City
Plavin, Nathan J., 8010 Boulevard, North Bergen
Pontery, Herbert B., 89 Bowers st., Jersey City
Potter, Benjamin P., 100 Clifton pl., Jersey City
Price, H. Preston, Army
Prince, Samuel, Army
Purdy, Charles H., 35 Highland av., Jersey City
Pyle, Wallace, 15 Exchange pl., Jersey Ctiy
Quigley, Frederic J., 543 45th st., Union City
Quinn, John J., 921 Bergen av., Jersey City
Reznikoff, Leon, Hudson Co. Mental Hosp.,Secaucus
Richmond, Samuel V., Medical Center, Jersey City
Rieck, Walter R., 379 Kearny av., Kearny
Rieman, Aloysius P., 3566 Boulevard, Jersey City
Rosen, Charles E., Army
Rosenberg, Albert B., 69 Myrtle av., N. Plainfield
Rosenberg, Jacob, 692 Bergen av., Jersey City
Rosenstein, Jacob L., 568 Bergen av., Jersey City
Rossl, John R., 119 W. 36th st., Bayonne
Rubenstein, Eli, 800 Avenue C, Bayonne
Rubenstein, Robert, 2758 Boulevard, Jersey City
Ruffer, Ralph A., 1406 West st., Union City
Rundlett, Emilie V., 79 Prospect st., Jersey City

Ruoff, Andrew C., 2414 New York av., Union City
Russell, David L., 690 Bergen av., Jersey City
Sabini, Cecil F., 603 Jefferson st., Hoboken
Sacco, Anthony G., 2200 New York av., Union City
Sachs, Wilbert, 921 Bergen av., Jersey City
Sager, Harold, 19 W. 22nd st., Bayonne
Sakowski, John P., 20 W. 22nd st., Bayonne
Saladino, Anthony J., 427 15th st., Union City
Salmon, Edward F., 50 Gifford av., Jersey City
Santangelo, Stephen, 461 Jersey av., Jersey City
Santosky, Benjamin B., Army
Saradarian, Albert V., Army
Schenker, Benjamin N., 246 Fifth st., Jersey City
Schenker, Israel N., 3697 Boulevard, Jersey City
Schenker, Sarah S., 1009 Garden st., Hoboken
Schept, Samuel S., 523 37th st., Union City
Schimenti, Matteo, 1893 Boulevard, Jersey City
Schlein, August, 707 Park av., Hoboken
Schneider, Harry M., 89 Gifford av., Jersey City
Schneider, Louis A., 412 61st st., West New York
Schuchner, William F., 550½ Jersey av., Jersey City
Schuck, Traugott J., 58 Ninth st., Hoboken
Schwab, George P., 514 73rd st., North Bergen
Schwartz, Harold B., 2157 Boulevard, Jersey City
Schwarz, Berthold T. D., 2787 Boulevard, Jersey City
Schwarz, Henry J., Army
Schwarzwald, Irving, Navy
Sciarrillo, Louis F., 105 Newark st., Hoboken
Scott, John J., Army
Scott, Samuel G., 141 Bergen av., Jersey City
Seligmann, Fred S., 501 32nd st., Union City
Selinger, Samuel, 413 60th st., West New York
Shapiro, Saul J., Army
Shook, Benjamin E., 284 Bergen av., Jersey City
Shulman, Nathan L., 538 45th st., Union City
Siegel, Lester, Army
Sigman, George, 254 Union st., Jersey City
Silich, Robert L., Army
Silon, Milton R., 907 Washington st., Hoboken
Silvera, Salomon, 532 Bergen av., Jersey City
Simeone, Peter A., 138 Clerk st., Jersey City
Simpson, David B., 818 Avenue C, Bayonne
Singer, Sina S., 3443 Boulevard, Jersey City
Sinnott, Gerald W., Medical Center, Jersey City
Smith, Arthur B. R., Navy
Smith, Meyer, 14 Webster av., Jersey City
Snyder, W. Jay, 74 Columbia ter., Weehawken
Solomon, Louis, 7 Tonnele av., Jersey City
Spano, Frank, Navy
Spath, William H., Army
Spohn, Eugene L., Navy
Sprague, Seth B., 301 York st., Jersey City
Stankiewicz, F. Stanley, 113 Audubon av., JerseyC'y
Starr, Benjamin, 96 Sherman pl., Jersey City
Stefansin, Frank, Navy
Stein, Albert, 600 80th st., North Bergen
Stein, Jacob M., 68 Columbia ter., Weehawken
Stockfisch, Robert H., 3637 Boulevard, Jersey City
Stokes, Anthony T., 819 First st., Secaucus
Stuart, William C., 518 Hudson st., Hoboken
Sussman, Harold, 1122 Garden st., Hoboken
Swiney, Juliana C., 325 Avenue C, Bayonne
Swiney, Merrill A., 325 Avenue C, Bayonne
Taft, Herman L., Army
Tannert, Carl H., 331 77th st., North Bergen
Tataryan, Hovsep, 2024 New York av., Union City
Temes, J. Howard, Army
Terwedow, Henry, 518 79th st., North Bergen
Terwedow, Walter G., 518 79th st., North Bergen
Toth, Elmer F., Army
Tyndall, Hugh H., 83 Highwood ter., Weehawken
Urevitz, Abraham, 2415 New York av., Union City
Utkewicz, Edmond A., 2633 Boulevard, Jersey City
Varriano, John L., Navy
Vespignani, Pasquale, 863 Montgomery st., Jer. City
Visconti, Joseph A., 105 Newark st., Hoboken
Viti, Henry A., 274 Barrow st., Jersey City
Vostrosablin, Nicholas A., 121 Grand st., Jersey City
Wallack, Eli A., 92 Fairview av., Jersey City
Waters, Edward G., 39 Gifford av., Jersey City
Watman, Anthony J., 2784 Boulevard, Jersey City
Weber, Laura E., 305 23rd st., Union City
Weber, Walter D., 305 23rd st., Union City
Weigele, Carl E., 143 East State st., Trenton
Weiss, Abram, 2302 Palisade av., Weehawken
Weiss, Morris J., 734 Avenue C, Bayonne
Wheeler, James A. V., 85 VanReypen st., JerseyCity
White, Thomas J., 50 Glenwood av., Jersey City
Wichman, Heins, 2672 Boulevard, Jersey City
Wilcox, Frank A., Army
Woelfle, Henry E., 907 Summit av., Jersey City
Wolbert, Charles M., Army
Woltz, Sidney, 2206 New York av., Union City
Yeaton, William L., Jr., 204 11th st., Hoboken
Yontef, Reuben, 851 Avenue C, Bayonne
Yudkoff, William, Army
Yunck, William P., Jr., Army
Zitani, Alfred M., 937 Washington st., Hoboken

Number of Active Members and basis of representation, 432.

HONORARY MEMBERS

Connell, John, Jersey City
Gille, Hugo, Jersey City
Older, Benjamin, Miami Beach, Florida
Rosecrans, James M., Hoboken
Sexsmith, George H., Los Angeles, California
Smith, Alexander L.
Stout. J. Philip, Jersey City

HUNTERDON COUNTY (10)

Society organized June 12, 1821. Meets on fourth Tuesday of January, April, July, and October, April being the Annual Meeting.

ACTIVE MEMBERS

Baker, Philip W., High Bridge
Bambara, Aurelius J., Flemington
Beatty, Hannah J., Clinton Farms, Clinton
Boyer, Charles G., Annandale
Clark, Frank G., White House Station
Coleman, Austin H., Clinton
Crooks, William J., III, N. J. State Hosp.,GlenGard'r
Ctibor, Vladimir F., Califon
Decker, Frederick H., Frenchtown
English, Samuel B., N. J. State Hosp., Glen Gardner

Fluck, Paul H., 73 N. Union st., Lambertville
Fritz, John F., Jr., 95 Main st., Flemington
Fuhrmann, Barclay S., 10 Main st., Flemington
Garfinkel, Abraham, 30 Broad st., Flemington
Germain, Raymond J., High Bridge
Hamilton, Lloyd A., 46 York st., Lambertville
Henry, George, 33 Mine st., Flemington
Jenkins, Arthur M., 701 Harrison st., Frenchtown
Knox, Howard A., New Hampton
Lane, Edgar W., 46 Main st., Bloomsbury
Leaver, Morris H., Quakertown
McCorkle, William E., Ringoes
Merrill, Edwin D., Army
Moran, John F., Jr., Army
Mullins, Roy L., 305 Harrison st., Frenchtown
Shangold, Jack E., Army
Stolow, Alan A. J., N. J. State Hosp., Glen Gardner
Tompkins, Grenelle B., 52 Broad st., Flemington

Number of Active Members and basis of representation, 28.

HONORARY MEMBERS

Morrison, J. Bennett, Vista, California
Scammell, Frank G., Trenton
Sommer, George N. J., Trenton

MERCER COUNTY (11)

Society organized May 23, 1848. Meets on second Wednesday of each month except July, August, and September, at 9:00 p. m., in the State Society Headquarters, Trenton. Annual Meeting in December. Annual Banquet in November.

ACTIVE MEMBERS

Abey, William J. H., 65 S. Main st., Pennington
Ackley, David B., 21 N. Clinton av., Trenton
Albert, Perry, Army
Anthony, David W., 201 Witherspoon st., Princeton
Applegate, Edw. T. R., 1125 Greenwood av., Trenton
Applestein, Robert, 568 E. State st., Trenton
Aronis, Harry R., 935 W. State st., Trenton
Ashley, Harmon H., 20 Nassau st., Princeton
Austin, Henry J., 96 Bellevue av., Trenton
Barlow, John D., Army
Barrows, Arthur M., 440 Hamilton av., Trenton
Barry, R. Grant, 908 W. State st., Trenton
Bayne, Joseph K., Army
Beairsto, Everett B., 224 W. States st., Trenton
Belfer, Jacob J., 1235 Chambers st., Trenton
Belford, Ralph J., 90 Nassau st., Princeton
Bellis, Horace D., 437 E. State st., Trenton
Bennett, Robert E., Army
Bergsma, Daniel, Army
Berman, Jacob J., 409 Market st., Trenton
Bernstein, Bertram, 35 Boudinot st., Trenton
Berry, Leonard M., 205 Nassau st., Princeton
Blackwell, Enoch, 28 W. State st., Trenton
Blaugrund, Samuel, 833 W. State st., Trenton
Bonnet, W. Laurence, 2791Not'gham way,Mercerv'le
Borrella, Domenic D., 476 Hamilton av., Trenton
Buckley, Richard T., Jr., Peddie School, Hightstown
Burbidge, J. Raymond, 10 Bayard lane, Princeton
Burns, Joseph R., 254 S. Olden av., Trenton
Burroughs, Edmund W., Army
Byer, M. Yale, 442 Greenwood av., Trenton
Carabelli, A. Albert, 306 Hamilton av., Trenton
Carroll, C. Walter, 125 Centre st., Trenton
Carroll, William V., 211 Academy st., Trenton
Cella, Charles F., 359 Hamilton av., Trenton
Charleroy, Durant K., 38 Crosswicks st., Bordent'n
Charnock, Maurice P., 104 Perry st., Trenton
Chesner, William A., 1111 Hamilton av., Trenton
Chianese, C. Chester, 464 Hamilton av., Trenton
Clark, Alice L., 206 W. State st., Trenton
Clunan, Ambrose P., 851 Hamilton av., Trenton
Cohan, Charles C., 217 W. Hanover st., Trenton
Cohan, Joseph, 217 W. Hanover st., Trenton
Cohen, Herman, Army
Cohen, William, 1007 Greenwood av., Trenton
Colavita, James J., 433 Princeton av., Trenton
Comfort, John B., 50 S. Clinton av., Trenton
Commini, Frank F., 439 Bellevue av., Trenton
Corio, George A., 307 S. Clinton av., Trenton
Corrigan, Patrick H., 1720 S. Broad st., Trenton
Cotton, Henry A., Jr., Lawrenceville rd., Princeton
Cottone, R. John, 683 Princeton av., Trenton
Cowlbeck, H. Donald, 224 W. State st., Trenton
Cox, Harold C., 208 Stockton st., Hightstown
D'Arcy, Walter E., 545 E. State st., Trenton
Davenport, Irwin P., 545 W. State st., Trenton
Davis, Harold L., 178 W. State st., Trenton
Davis, John E., Jr., New Jersey State Hosp.,Trenton
Davison, Royden W., 205 W. State st., Trenton
Dean, Guy K., Jr., Princeton rd., Plainsboro
Deitz, Joseph R., 320 Centre st., Trenton
Dembinski, T. Henry, Army
Denelsbeck, J. Otis, 878 E. State st. T,renton
Dimun, John T., 1000 S. Broad st., Trenton
Dodge, James T., 1819 S. Broad st., Trenton
Doranz, Harold K., Army
Drezner, Henry L., 507 S. Warren st., Trenton
Dzienis, John, 1767 S. Broad st., Trenton
Eames, William N., 1871 Pennington rd., Trenton
Elias, Elmer J., 474 Greenwood av., Trenton
Engelhart, Ferdinand K., 28 Oak lane, Trenton
English, Harrison F., III, 9 H'wl't st.,Waterb'y,Conn.
Ernest, Richard B., 240 W. State st., Trenton
Fabian, Paul L., 520 Princeton av., Trenton
Farmer, Walter D., 28 S. Main st., Allentown
Fessler, A. James, 1544 S. Broad st., Trenton
Fine, Sydney G., 868 Stuyvesant av., Trenton
Finegan, Paul J., Army
Finkle, Lester J., 225 Perry st., Trenton
Fiorello, Joseph R., 689 Princeton av., Trenton
Fluck, David A., 626 W. State st., Trenton
Forer, Robert, Army
Franzoni, Andrew E., 938 Brunswick av., Trenton
Friedman, Max, 849 W. State st., Trenton
Friedman, Meyer H., 526 N. Clinton av., Trenton
Friedmann, Leonard L., 484 Princeton av., Trenton
Fuchs, Jacob N., 1267 S. Broad st., Trenton
Garwood, Norman W., Main st., Crosswicks
Gindhart, John H., 1233 Hamilton av., Trenton
Goldberg, Benjamin M., 1156 E. State st., Trenton
Goldman, Leo L., 325 Market st., Trenton
Graham, Ernest E., 4273 S. Broad st., Yardville
Gribbin, James A., 836 W. State st., Trenton
Guglielmelli, Angelo D., 449 Hamilton av., Trenton

Guidotti, Frank P., Army
Hafetz, M. Morris, 114 Centre st., Trenton
Haggerty, D. Leo, 227 N. Warren st., Trenton
Hammell, Frank M., Navy
Haney, John J., 850 Hamilton av., Trenton
Harman, J. Reginald, 824 W. State st., Trenton
Harman, William J., 740 W. State st., Trenton
Hess, George A., Titusville
Hiden, Joseph C., 199 Nassau st., Princeton
Hirschfield, Bernard A., Army
Hofbauer, Ernest, 695 Parkway av., Trenton
Horhovitz, George I., 324 S. Broad st., Trenton
Hunter, Floyd D., 3620 Nottingh'm way,HamiltonSq.
Hutchinson, A. Dunbar, 913 W. State st., Trenton
Hutchinson, Geo. F., 55 Mercer st., Hamilton Square
Ivins, William C., 455 W. State st., Trenton
James, J. Thomas, 57 Wiggins st., Princeton
Janoff, Henry, 626 Perry st., Trenton
Jaspan, Samuel C., 820 Division st., Trenton
Johnson, John F., 120 Buckingham av., Trenton
Kachdorian, Vartan, 935 Brunswick av., Trenton
Kinczel, John A., 971 S. Broad st., Trenton
Klempner, Paul, 637 Greenwood av., Trenton
Kline, Joseph J., 733 Hamilton av., Trenton
Knauer, Charles H., Jr., 198 W. State st., Trenton
Kohn, Joseph J., 820 Berkeley av., Trenton
Kohn, Ralph B., 820 Berkeley av., Trenton
Kondor, Joseph S., 978 S. Broad st., Trenton
Koplin, Nathaniel H., 142 W. State st., Trenton
Kustrup, John F., 1418 S. Broad st., Trenton
Lapin, Louis P., 15 Crosswicks st., Bordentown
Lapin, Samuel B., Army
Larsson, Evert A., Navy
Lavine, Barney D., 630 N. Clinton av., Trenton
Lavine, Sidney B., 144 W. State st., Trenton
Leshin, Harry, 564 S. Main st., Hightstown
Lettiere, Anthony J., 425 E. State st., Trenton
Levin, Louis, 651 W. State st., Trenton
Levy, Irvin, 222 W. State st., Trenton
Light, Arthur B., Lawr'ceville Sch'l, Lawrenceville
Little, William R., 493 W. State st., Trenton
Lloyd, Samuel J., Army
Lynch, Donald C., 885 Stuyvesant av., Trenton
MacDermid, Lynden E., 506 Farnsw'th av.,Bordent'n
Magee, Harold S., New Jersey State Hosp., Trenton
Magson, Albert E., 302 S. Main st., Highttstown
Majeski, Henry J., 930 Brunswick av., Trenton
McCandliss, William K., N. J. State Hosp., Trenton
McCarthy, William P., 1203 Parkside av., Trenton
McCullough, John H., 523 E. State st., Trenton
McGuigan, Francis A., 212 N. Warren st., Trenton
Means, Paul B., N. J. State Hospital, Trenton
Miller, Earle K., 2502 Nottingham way, Trenton
Miller, Gerald H., N. Main st., Cranbury
Miller, Reginald C., 1420 Greenwood av., Trenton
Miller, Samuel R., 407 S. Main st., Pennington
Minschwaner, Geo. G., Jr., 939 Greenw'd av.,Trenton
Mitchell, Charles H., 1100 W. State st., Trenton
Mitskas, Theo. V. J., 1329 Greenwood av., Trenton
Moriconi, Albert F., 438 Hamilton av., Trenton
Mountford, William E., 215 N. Warren st., Trenton
Munro, Jeannette, 2 Queenston pl., Princeton
Murphy, James A., 312 Bellevue av., Trenton
Murto, Thomas V., 117 Buckingham av., Trenton
Nayfield, Romald C., 974 S. Broad st., Trenton
Nonziato, Frank A., 50 Centre st., Trenton
North, Harry R., 160 W. State st., Trenton
Ogden, Andrew E., 1829 Greenwood av., Trenton
O'Neill, Joseph F., 41 E. Broad st., Hopewell
O'Rourke, James J., 871 Stuyvesant av., Trenton
Pantaleone, Joseph, 504 Hamilton av., Trenton
Parker, Horace N., 72 N. Clinton av., Trenton
Pepe, Salvatore A., 638 Perry st., Trenton
Pessel, Johannes F., 224 W. State st., Trenton
Peterson, Walter R., 312 W. State st., Trenton
Pierson, Carl L., 395 W. State st., Trenton
Pierson, Joseph R., 10 E. Broad st., Hopewell
Pinerman, Robert B., 308 W. State st., Trenton
Pittman, Allen R., N. J. State Hospital, Trenton
Potter, Ellen C., 301 W. State st., Trenton
Powis, Ethel M., 845 W. State st., Trenton
Poyas, Morton L., 306 W. State st., Trenton
Preece, John D., 178 W. State st., Trenton
Proctor, Francis E., 332 W. State st., Trenton
Purcell, Ernest F., 800 Stuyvesant av., Trenton
Quackenbos, Harrie M., N. J. State Hosp., Trenton
Ragany, Joseph, 966 S. Broad st., Trenton
Rainey, Willard G., 34 Bayard lane, Princeton
Rampona, Joseph M., 272 Nassau st., Princeton
Reisinger, Paul B., 369 W. State st., Trenton
Rita, James J., 235 S. Clinton av., Trenton
Rogers, Laurence H., Donnelly Mem. Hosp., Trenton
Rose, William G., 232 Stockton st., Hightstown
Rowan, Henry M., 224 W. State st., Trenton
Sackin, Stanley, 834 W. State st., Trenton
Salvatore, Joseph T., 324 Hamilton av., Trenton
Salway, Benjamin, 321 S. Broad st., Trenton
Scammell, Frank G., 40 S. Clinton av., Trenton
Scasserra, Benedict B., 163 Nassau st., Princeton
Schildkraut, Jacob M., 170 W. State st., Trenton
Seely, Roy B., 104 N. Clinton av., Trenton
Seitzick-Robbins, H. E., 723 W. State st., Trenton
Sekerak, Albert J., 984 S. Broad st., Trenton
Shear, M. Murray, 1158 E. State st., Trenton
Sica, L. Samuel, 431 E. State st., Trenton
Siemion, Theophilis R., 1005 Brunsw'k av., Trenton
Sill, John B., 942 W. State st., Trenton
Silver, E. Drew, 136 Stockton st., Hightstown
Slack, Clarence J., 230 W. State st., Trenton
Smith, Frank W., 1238 S. Clinton av., Trenton
Snegireff, Leonid S., 932 Parkside av., Trenton
Sommer, George N. J., 120 W. State st., Trenton
Sommer, George N. J., Jr., 120 W. State st., Trenton
Spradley, Jeems B., N. J. State Hospital, Trenton
Stabile, John A., Grand av., West Trenton
Steel, John M., N. J. State Hospital, Trenton
Stein, Louis A., 226 W. State st., Trenton
Storaci, Frank S., 715 Hamilton av., Trenton
Summers, Alfred D., 180 Nassau st., Princeton
Sutnick, Theodore B., Box 771, Trenton
Swern, Nathan, 399 W. State st., Trenton
Swertfeger, Herbert W., 22 N. Greenw'd av.,Hopew'l
Tenney, Luman H., Navy
Tomec, Otto C., Army
Treiber, Benjamin A., 219 W. State st., Trenton
Tretter, Hans L., 501 W. State st., Trenton
Urbaniak, Henry S., 883 Brunswick av., Trenton
Vaczi, Stephen, 983 S. Broad st., Trenton
Vanneman, Joseph S., 45 Princeton av., Princeton
Vento, Sebastian J., Army
Vol-Tretter, Marta, 501 W. State st., Trenton
Waldron, Edward L., 910 Stuyvesant av., Trenton
Walsh, Thomas J., 514 Greenwood av., Trenton
Warter, Peter J., 717 W. State st., Trenton
Waters, Charles H., 928 W. State st., Trenton
Watov, Samuel E., 615 Beatty st., Trenton
Watson, Frederick S., 238 W. State st., Trenton
Watts, Wilbur, 436 E. State st., Trenton
Wayman, Bernard R., 1203 W. Erie st., Phila., Pa.
West, Edgar L., 443 E. State st., Trenton
Wiesler, Howard M., Drawer N, Trenton
Wikoff, John L., 799 Pennington av., Trenton
Williams, Harry D., 829 W. State st., Trenton
Wilner, Arthur S., 205 Market st., Trenton
Wilner, Irving, Army
Wittenborn, W. F. J., 1635 Brunswick av., Trenton

Wolff, Herbert M., Army
Yaeger, Leslie A., 470 Hamilton av., Trenton
York, Wilbur H., Box 110, Princeton
Zimskind, Joshua N., 210 W. State st., Trenton

Number of Active Members and basis of representation, 244.

ASSOCIATE MEMBERS

Edwards, Walter R., 22 Annabelle av., Trenton
Folmer, Edward, 730 S. Olden av., Trenton
Franklin, Charles M., Army
Gahan, Emanuel, 178 W. State st., Trenton
Gindhart, Floyd, 1233 Hamilton av., Trenton
Goyne, James B., 2785 Main st., Lawrenceville
Granger, James R., 235 Spring st., Trenton
Kren, Frank, 718 W. State st., Trenton
Lapin, Mathew R., 628 W. State st., Trenton
Marshall, Irving, Medical Center, Jersey City
Mather, William B., 36 Edwards pl., Princeton
Prunetti, Carmen, 311 Chestnut av., Trenton
Rosso, John D., Princeton Hospital, Princeton
Smith, B. Earl, 1017 Greenwood av., Trenton
Smith, DeWitt H., 194 Nassau st., Princeton
Smith, Percy L., 178 W. State st., Trenton
Straus, Walter, 1239 Greenwood av., Trenton
Usher, Glenn S., U.S.P.H.S.

HONORARY MEMBERS

Fell, Alton S., Trenton
MacFarland, Burr W., Trenton
Pierson, Theodore A., Hopewell
Taylor, Walter A., Trenton
Turner, Irvine F. P., Titusville
Wright, Howard E., Princeton

MIDDLESEX COUNTY (12)

Society organized June 11, 1816. Meets on the third Wednesday of each month, October to June, inclusive. Annual Meeting in December.

ACTIVE MEMBERS

Adler, Howard E., 103 Livingston av., New Bruns'k
Anderson, John F., 195 College av., New Brunswick
Avery, Philip S., Woodland ter., Bound Brook
Balogh, William A., 315 Front st., Dunellen
Barbano, Alfred J., 225 Hale st., New Brunswick
Bassett, Lavern C., 320 New Market rd., Dunellen
Belafsky, Henry A., 150 Green st., Woodbridge
Berkow, Samuel G., 138 Market st., Perth Amboy
Bowman, Ned O., Navy
Breslow, Samuel, 157 Market st., Perth Amboy
Brody, Morton S., 67 Paterson st., New Brunswick
Calvin, Charles H., 80 Commerce st., Perth Amboy
Clarke, Francis M., 116 New st., New Brunswick
Cole, Nathaniel B., Navy
Cooper, Irving J., 419 George st., New Brunswick
Cooperman, Eli L., 527 New Brunswick av., Fords
Copleman, Benjamin, Army
Copleman, Hyman B., 111 Liv'gst'n av.,NewBruns'k
Cottrell, Judson G., 159 Market st., Perth Amboy
Cronk, Edwin I., 57 Livingston av., New Brunswick
Degenhardt, Ira H., 114 S. First st., Highland Park
Dieker, Howard E., 78 Main st., South River
Downing, Perley E., N. J. State Hospital, Trenton
Downs, Louis S., Army
Dunham, Malcolm M., 88 Grove av., Woodbridge
Duschock, Edward F., 473 Amboy av., Perth Amboy
East, Isaac C., State Home for Boys, Jamesburg
Eulner, Elmer H., 216 Henry st., South Amboy
Fagan, James L., 51 Bayard st., New Brunswick
Fanelli, Antonio, 494 Compton av., Perth Amboy
Faulkingham, Ralph J., 61 Liv'gst'n av.,NewBr'ns'k
Feher, Ladislas A. M., 177 Somerset st., NewBr'ns'k
Fine, Hyman P., 151 Market st., Perth Amboy
Fine, Irvin J., Hobart Bldg., Perth Amboy
Fishkoff, Alexander H., 132 Market st.,Perth Amboy
Fithian, George W., 266 High st., Perth Amboy
Forney, Norman N., 94 N. Main st., Milltown
Forney, Norman N., Jr., Stelle av., Milltown
Forrest, Henry, Army
Friedenthal, Bernard, 88 Livingtson av.,NewBr'ns'k
Gadek, Stanley A., 95 Fayette st., Perth Amboy
Gadek, William V., Army
Gauzza, Valentine P., 505 New Brunswick av., Fords
Gerard, Arpad G., 502 Rahway av., Woodbridge
Gessner, Gerard R., 46 Union st., New Brunswick
Glasser, Benjamin F., Army
Gobel, Stanley J., 79 Talmadge av., Bound Brook
Goldberg, Harry C., 7 Watchung av., Plainfield
Goldberg, Isidore, 303 N. Washington av., Dunellen
Goldman, Solomon, 161 Livingston av., New Br'ns'k
Gorog, Nicholas M., 159 Bayard st., New Brunswick
Greenwood, Wm. R., 106 College av., New Brunsw'k
Gurshman, Sol, Army
Gutowski, Joseph M., 433 Brace av., Perth Amboy
Haight, Harry W., 118 Raritan av., Highland Park
Hauber, Eugene A., 198 Washington rd., Sayreville
Haywood, Henry, 49 Paterson st., New Brunswick
Henry, Frank C., Jr., 214 Smith st., Perth Amboy
Hesseltine, Clair E., 305 Main st., South Amboy
Hilker, George F., 258 Maple st., Perth Amboy
Hinton, Samuel H., 123 Main st., Sayreville
Hofer, Clarence J. M., 463 Main st., Metuchen
Hoffman, Charles W., 226 David st., South Amboy
Hoffman, Florentine M., 91 Bayard st., New Bruns'k
Howell, E. Gaylord, 120 New st., New Brunswick
Howley, Barth, Jr., Navy
Hunt, Melvin M., 140 Jackson st., South River
Hutner, Cyrll I., 134 Grove av., Woodbridge
Jablonski, John J., Army
Jacobson, Murray B., 137 Market st., Perth Amboy
Karshmer, Nathan, 92 Carroll pl., New Brunswick
Kay, Albert E., 115 Minna av., Avenel
Kelly, Leo J., Army
Kemeny, Imre, 48 Pulaski av., Carteret
Kleiber, Estelle E., 131 Livingston av.,New Brunsw'k
Klein, Alexander, 215 High st., Perth Amboy
Klein, Edward F., 136 Market st., Perth Amboy
Klein, William, 85 Bayard st., New Brunswick
Kler, Joseph H., 151 Livingston av., New Brunswick
Koelsch, Frederick J., 14 Kirkpatrick st.,NewBr'ns'k
Kohut, George J., Army
Krafchik, Louis L., 100 Bayard st., New Brunswick

Kramer, Bernard M., Navy
Kramer, Samuel E., 254 State st., Perth Amboy
Lang, Joseph, 111 Market st., Perth Amboy
Lavine, Samuel C., 502 Georges rd., New Brunswick
Lazow, S. Manlius, 199 Main st., Matawan
Leonard, George F., 63 N. 5th av., Highland Park
Levinson, Reuben, 123 Market st., Perth Amboy
Lewis, Collins E., 219 Seaman st., New Brunswick
Lief, Lawrence H., Gatzmer av., Jamesburg
Lind, Zoltan H., 215 Livingston av., New Brunswick
London, William, 255 State st., Perth Amboy
Long, Pauline A., 22 Livingston av., New Brunswick
Lucey, James J., 184 Market st., Perth Amboy
Mangogna, Philip, 334 Barclay st., Perth Amboy
Mann, Benjamin, 527 Amboy av., Perth Amboy
Mann, Jacob J., 255 State st., Perth Amboy
Margaretten, Edward I., 280 Hobart st., PerthAmb'y
Mark, Joseph S., 102 Green st., Woodbridge
Marvin, Dorothy H., 51 Livingston av., New Br'sw'k
McCormick, Wm. H., Jr., 266 Market st., P'thAmboy
McGovern, John F., Jr., 24 Liv'gst'n av.,NewBr'ns'k
McKiernan, Robert L., 97 Bayard st., New Brunsw'k
McKinstry, John W., Railroad av., Jamesburg
McLaughlin, Thomas F., 596 Main st., Metuchen
McLeod, Neill S., 729 Raritan av., Highland Park
Meacham, Eugene A., 112 Stevens av., So. Amboy
Meinzer, Martin S., 147 Market st., Perth Amboy
Merrill, Charles F., 16 S. Third av., Highland Park
Messinger, Samuel, 31 Roosevelt av., Carteret
Miller, George M., Army
Miller, S. David, 90 Carroll pl., New Brunswick
Morris, Carlyle, Spring street, Metuchen
Nafey, Herbert W., 51 Livingston av., NewBrunsw'k
Naulty, Chas. W., Jr., 403 High st., Perth Amboy
Nieman, Solomon Z., 191 Livingston av., NewBr'ns'k
Normand, Alphonse F., Army
O'Connell, James J., 116 Livingston av., NewBr'ns'k
Panigrosso, Louis R., Navy
Pansy, Abraham A., 12 Jackson st., South River
Pearson, J. Gerald, 75 Livingston av., New Brunsw'k
Pellicane, Anthony J., 183 Liv'gst'n av., New Br'ns'k
Platt, Thomas H., 307 N. Washington av., Dunellen
Racz, George, Army
Reason, John J., 612 Roosevelt av., Carteret
Reitman, Norman, Army
Rineberg, Irving E., 137 Livingston av., NewBr'ns'k
Rona, Maurice, 10 Kirkpatrick st., New Brunswick
Rothfuss, C. Howard, 574 Rahway av., Woodbridge
Rothschild, Karl, 149 Livingston av., New Brunsw'k
Rowland, John H., 159 New st., New Brunswick
Rubin, Benjamin, Army
Rubin, William, 90 Bayard st., New Brunswick
Runyon, Laurence P., 80 Somerset st., New Bruns'k
Salaky, William L., 387 Neville st., Perth Amboy
Sandella, Jos. F., 138 Livingston av., New Brunsw'k
Saulsberry, Chas. E., 75 Livingston av., New Br'ns'k
Schirber, Rene G., 11 Kirkpatrick st., New Brunsw'k
Scott, Frederick W., 103 Bayard st., New Brunswick
Sender, Fannie, 193 Main st., South River
Shayevitz, Abraham S., 102 Main st., South River
Sherman, W. Edgar, 7 Livingston av.,NewBrunsw'k
Shull, John V., 184 Kearny av., Perth Amboy
Siegel, Isadore, 121 Market st., Perth Amboy
Silk, Charles I., 236 High st., Perth Amboy
Slobodien, Benjamin F., 233 High st., Perth Amboy
Smith, Ivan B., George rd., Dayton
Smith, John A., 106 Main st., South River
Smith, John V., 463 State st., Perth Amboy
Smith, Joseph A., Roosevelt Hospital, Metuchen
Smith, Marshall, 62 Bayard st., New Brunswick
Smith, Sydney F., Army
Sokoloff, Oscar J., Army
Spritzer, Theodore D., Army
Steffens, Charles T., 307 N. Washington av.,Dunellen
Stein, William, 177 Livingston av., New Brunswick
Sullivan, Chas. J., 57 Paterson st., New Brunswick
Szuch, Nicholas, 159 Main st., South River
Taber, Frederick S., 128 Graham st., New Brunswick
Tisch, Leon, 28 S. Third av., Highland Park
Toy, Calvert R., Army
Tucker, Sidney, 182 Market st., Perth Amboy
Uhr, Jacques S., 127 Livingston av., New Brunsw'k
Ulan, Jerome, Main st., Spotswood
Urbanski, Matthew F., 148 Market st., Perth Amboy
Van Mater, John S., Navy
Vargyas, Joseph C., 116 New st., New Brunswick
Walker, Robert B., 108 Church st., New Brunswick
Walters, George M., 158 Main st., Woodbridge
Wantoch, Joseph, 14 Carteret av., Carteret
Weber, John F., 264 Main st., South Amboy
Weiner, Henry T., 280 Hobart st., Perth Amboy
Wetterberg, Louis F., 74 Grove av., Woodbridge
White, Harry J., Roosevelt Hospital, Metuchen
Wiesenfeld, Benjamin, U.S.P.H.S.
Wilentz, William C., 188 Market st., Perth Amboy
Witmer, John D., 456 Middlesex av., Metuchen

Number of Active Members and basis of representation, 178.

ASSOCIATE MEMBERS

Adler, Lydia, 103 Livingston av., New Brunswick
Brezinski, Edward J., 473 Amboy av., Perth Amboy
Cannata, Benjamin, 113 Market st., Perth Amboy
Church, Charles F., Hillcrest, River rd.,NewBr'sw k
Finnegan, William R., 265 Handy st., New Brunsw'k
Freeman, William S., 117 N. Third av.,HighlandPark
Grossman, Walter, 77 Livingston av., NewBrunsw'k
Hamburg, Meyer M., 60 N. Sixth av., Highland Park
Idelcowitz, Marie, 123 Main st., South River
Jacobson, Benjamin D., 187Livingston av.,NewBr's'k
Koenig, Robert E., Sedgwick st., Jamesburg
Kunderman, Philip J., 215 Harper st., HighlandPark
Marino, Benjamin, E. R. Squibb & Sons, NewBr'ns'k
Putter, Eric, 180 N. Main st., Milltown
Romano, Frank, 930 Park av., Plainfield
Rosenberg, Norman, Army
Siegel, Ralph E., 111 Market st., Perth Amboy
Silber, Irving M., 75 Livingston av., New Brunswick
Walker, Otto, 198 Pershing av., Carteret
Wiesenfeld, Paul, 104 Market st., Perth Amboy

HONORARY MEMBERS

Applegate, Grover T., New Brunswick
Burnett, Charles B., South River
Collins, James J., Woodbridge
Henry, Frank C., Perth Amboy
Lund, John L., Perth Amboy
Spencer, Ira T., Woodbridge
Tyrrell, George W., Perth Amboy
Voorhees, Howard C., New Brunswick

MONMOUTH COUNTY (13)

Society organized July 24, 1816. Meets on fourth Wednesday of each month from September to June, inclusive. Annual Meeting in April.

ACTIVE MEMBERS

Albright, Louis F., 118 Madison av., Spring Lake
Altschul, Frank J., 177 Garfield av., Long Branch
Andrews, Thomas H., 111 Main st., Matawan
Baeseman, R. Winfield, 501 Grand av., Asbury Park
Baker, Elsworth F., N. J., State Hosp., Marlboro
Bar, Samuel, Englishtown
Barnett, Lester A., Grasslands Hosp., Valhalla, N.Y.
Becker, Sidney D., 140 Maple pl., Keyport
Binder, Joseph, 101 Third av., Long Branch
Blaisdell, C. Byron, 489 Broadway, Long Branch
Booth, Herbert W., 401 Ludlow av., Spring Lake
Bornstein, Paul K., 320 Asbury av., Asbury Park
Bossone, Joseph E., 172 Garfield av., Long Branch
Boyd, John B., 31 Oakland st., Red Bank
Bregman, Milton, 81 Union av., Manasquan
Brindle, Harry R., 501 Grand av., Asbury Park
Brown, Kenneth G., 501 Grand av., Asbury Park
Burkhead, Howard C., 177 Garfield av., LongBranch
Captanian, Aram A., 159 Main st., Matawan
Carey, David S., 11 E. Main st., Freehold
Carter, Joseph F. S., 142 Atkins av., Asbury Park
Casagrande, Stephen R., 320 Norwood av., Avon
Ciampa, Ralph P. E., 383 Bath av., Long Branch
Clark, John C., 501 Grand av., Asbury Park
Colby, Maxwell X., 133 Chelsea av., Long Branch
Costa, Philip L., 88 E. Front st., Red Bank
Daversa, Benjamin, 219 Madison av., Spring Lake
Delcau, Jules, 56 W. Main st., Freehold
Demaree, Richard H., 310 Norwood av, W.L'gBr'nch
DeVita, Anthony J., Wilson av., Port Monmouth
Diamond, David I., Oceanport av., Oceanport
Dorr, Henry B., 87 Washington st., Long Branch
Duvall, Albert I., N. J. State Hospital, Marlboro
Edelson, Samuel, 1611 Grand av., Asbury Park
Ellenson, Solomon S., 507 Fourth av., Asbury Park
Fazio, Vincent J., 104 Maple av., Red Bank
Featherston, Daniel F., 601 Bangs av., Asbury Park
Feinberg, Harry D., 384 Second av., Long Branch
Feldman, Joel, Rumson rd., Rumson
Feman, J. George, 141 Main st., Keansburg
Fenton, Tennant E., 320 Ludlow av., Spring Lake
Freedman, Harold H., 63 W. Main st., Freehold
Gesswein, Carl A., 35 Church st., Matawan
Glazer, Edward, 550 Cookman av., Asbury Park
Goff, Frank J., 62 Maple av., Red Bank
Goldberg, Jacob, 155 Franklin av., Long Branch
Gordon, J. Berkeley, N. J. State Hosp., Marlboro
Graves, Charles C., Jr., Navy
Haines, Emerson S., 500 Eighth av., Asbury Park
Halbstein, Bernard M., 138 Bath av., Long Branch
Hancock, Michael Q., 1204 Seventh av., Neptune
Hardy, John W., 53 Main st., Farmingdale
Hausman, Samuel W., 50 W. Front st., Red Bank
Heatley, William, Navy
Herrman, William G., 501 Grand av., Asbury Park
Heymann, Ernest F., 345 Broad st., Red Bank
Hindle, F. Lawton, 145 Maple av., Red Bank
Hodas, Sidney M., Army
Holman, Francis W., 123 Broad st., Keyport
Holters, Otto R., 1002 Emory st., Asbury Park
Ingling, Harry W., 51 W. Main st., Freehold
Jamison, William F., 501 Grand av., Asbury Park
Jones, Granville L., N. J. State Hospital, Marlboro
Jones, Helen E., 617 Seventh av., Asbury Park
Jordan, Joseph C., Army
Kazmann, Harold A., 3 E. Ninth st., New York City
Knapp, Victor, 505 Second av., Asbury Park
Levin, Jack, Jersey Homesteads, New Jersey
Lewis, Jack, 43 Court st., Freehold
Lorenzo, Michael J., Army
Luca, Frank, Westwood av., Long Branch
Luca, Mildred O., Westwood av., Long Branch
MacKenzie, Robert A., 501 Grand av., Asbury Park
Maher, John E., 90 Third av., Long Branch
Makin, John B., 501 Grand av., Asbury Park
Manahan, Daniel V., 55 E. Front st., Red Bank
Martin, Leonard J., 206 Prospect av., Asbury Park
Matthews, William, 139 Broad st., Red Bank
McCreight, David W., N. J. State Hosp., Marlboro
McDonnell, George J., 80 W. Main st., Freehold
McKelvie, Julius C., 55 Rockwell av., Long Branch
McTague, Robert S., 88 3rd av., Atlantic Highlands
Miele, Frank A., 314 Carr av., Keansburg
Miller, S. Thomas, Army
Mohair, John P., N. J. State Hosp., Marlboro
Mulligan, Edward W., 23 Monmouth st., Red Bank
Murphy, Charles M., 21 Main st., Farmingdale
Neiderhoffer, Sydney L., 469 Broadway,LongBranch
Nichols, Stanley H., 517 Broadway, Long Branch
Niemtzow, Frank, 55 E. Main st., Freehold
Opfermann, John L., 167 Bay av., Highlands
Osborn, A. Downey, 519 Sixth av., Belmar
Parry, Oliver K., 601 Bangs av., Asbury Park
Perrine, Cornelius C., 668 River rd., Fair Haven
Perrotta, Anthony J., 42 Harding rd., Red Bank
Pieper, Howard C., Shrewsbury
Pietri, Raoul, 501 Grand av., Asbury Park
Pignataro, Frank P., 81 Bridge av., Red Bank
Pleasants, Edward N., N. J. State Hosp., Marlboro
Podell, A. Alfred, 51 E. Front st., Red Bank
Pons, Carlos A., 501 Grand av., Asbury Park
Pregnall, James P., 501 Grand av., Asbury Park
Quirk, Martin A., 90 W. Front st., Red Bank
Raffetto, Joseph F., Navy
Reynolds, Donald G., 64 W. Main st., Freehold
Robinson, Ernest A., 149 Atkins av., Asbury Park
Robinson, William A., 62 Main av., Ocean Grove
Rosenthal, Abraham, 43 Third av., Atlantic Highl'ds
Rubin, Adrian D., 401 First av., Asbury Park
Rubin, Harold, 527 Bangs av., Asbury Park
Rullman, Walter A., 58 W. Front st., Red Bank
Sacco, Gregory E., 191 Broad st., Red Bank
Sayre, William D., Box 202, Red Bank
Schlossbach, Theodore, 94 S. Main st., Ocean Grove
Schmidt, Albert F., Navy
Sewell, Stephen, 320 Passaic av., Spring Lake
Shanik, William, Army
Slocum, Harry B., 263 Bath av., Long Branch
Stevenson, George S., West Front st., Red Bank
Stewart, Edwin F., 94 Fair Haven rd., Fair Haven
Strauss, Arthur, 130 Pavilion av., Long Branch
Trippe, Clarence M., 702 Asbury av., Asbury Park
Trippe, Morton F., 702 Asbury av., Asbury Park
Villapiano, Joseph G., 701 Sunset av., Asbury Park
Wainright, Melvin A. R., 286 Broad st., Red Bank
Wilbur, Franklin L., 515 Eighth av., Asbury Park
Wilkins, Stanley O., 47 E. Front st., Red Bank
Willey, Harry S., Jr., 112 Broad st., Red Bank
Wilson, Robert B., 91 Broad st., Red Bank
Woodruff, Ralph G., Main st., Englishtown
Woronoff, Murray, 120 Main st., Keyport
Worthington, Joseph A., 609 Fourth av.,BradleyB'ch

Number of Active Members and basis of representation, 132.

ASSOCIATE MEMBERS

Baer, Irving, 141 Broad st., Red Bank
D'Elia, William J., 2017 Fifth av., Spring Lake
Dengrove, Edward, N. J. State Hospital, Marlboro
Graeber, Irving, 500 Tenth av., Belmar
Koch, William, 1000 Grand av., Asbury Park
Long, Elias E., 85 W. Front st., Red Bank
McCurdy, Robert G., Atlantic Highlands
Nathanson, Norman, 489 Broadway, Long Branch
Rifici, Anthony L., 1010 Grand av., Asbury Park
Rocco, Leo C., 75 Maple av., Red Bank
Sahler, Otto DeP., 501 Grand av., Asbury Park
Siegel, Victor, 43 E. Front st., Red Bank

HONORARY MEMBERS

Bryan, Joseph H., Asbury Park
Ransohoff, Nicholas S., Long Branch
Straughn, Clinton C., Red Bank

MORRIS COUNTY (14)

Society organized June 11, 1816. Meets on the third Thursday in October, December, March and June. Annual Meeting in June.

ACTIVE MEMBERS

Alcaro, Joseph A., 16 W. Blackwell st., Dover
Atkinson, John M., 93 Greenwood av., Madison
Baker, Augustus L., 389 W. Blackwell st., Dover
Ballard, Wiliam C., Army
Beaver, Jennie D., 44 Elm st., Morristown
Benz, Francis J., 30 Lum av., Chatham
Bertha, Nicholas A., 301 S. Main st., Wharton
Bird, Frank L., Main st., Netcong
Blanchard, Charles L., 28 E. Blackwell st., Dover
Bobadilla, Juan E. B., Army
Booth, William K., 304 William st., Boonton
Bowers, F. Clyde, Mountain av., Mendham
Byrne, J. Arthur, 16 Elm st., Morristown
Cohen, Oscar H., 115 Church st., Boonton
Collins, Laurence M., N.J. State Hosp.,Greyst'ne P'k
Comeau, George W., 415 Speedwell av.,Morris Plains
Cook, Dora G., 135 Cornelia st., Boonton
Costello, William F., 55 W. Blackwell st., Dover
Coultas, Aldo B., 1 Madison av., Madison
Crandell, C. Archie, Army
Crane, Percy R., Box 224, Greystone Park
Cummins, Ella F., 39 Elm st., Morristown
Curry, Marcus A., N. J. State Hosp., Greystone Park
DeFelice, Mario T., Army
DeGregorio, Peter J., 56 Prospect st., Madison
Deichman, Charles H., 39 Elm st., Morristown
Dirdack, Morris, 13 DeHart st., Morristown
Dochtermann, Warren P., Army
Dredge, Thomas J., N. J. State Hosp., GreystonePk.
Earp, Ruth, 15 Olcott av., Bernardsville
Eckhardt, Ralph A., 50 Green Village rd., Madison
Emory, George B., Jr., 1 Franklin pl., Morristown
Esposito, Amedeo C., N. J. State Hosp.,GreystonePk.
Evans, Edgar J., Second av., Denville
Failmezger, Theodore R., 125 Green av., Madison
Falvello, Nicholas A., 28 Wetmore av., Morristown
Ferriss, Ruth B., 51 Maple av., Morristown
Forbes, John S., Jr., W. Craig st., Basking Ridge
Frost, Inglis F., 181 South st., Morristown
Gambill, Perry J., N. J. State Hosp., Greystone Park
Gantt, Margaret H., 43 Hillcrest rd., Madison
Geary, Daniel J., 40 Maple av., Morristown
Gebirtig, Theodore, N. J. State Hosp., GreystonePk.
Gilbertson, Robert L., 26 Maple av., Morristown
Giordano, Salvatore, 13 DeHart st., Morristown
Glazebrook, Francis H., "HoneysuckleW'ds,"Rumson
Gordon, Charles D., Mt. Arlington
Graddick, Lester W., 22 Sussex av., Morristown
Grant, Raymond J., 69 S. Morris st., Dover
Gregory, Marie F., 50 Green Village rd., Madison
Griscom, I. Norwood, 204 Church st., Boonton
Hampton, George R., N.J. State Hosp.,GreystonePk.
Harrington, J. Henry, 126 E. Main st., Rockaway
Hatch, Harold S., Shonghum Mt. Sana., Morristown
Haven, Samuel C., 14 Elm st., Morristown
Hiler, Stuart A., Navy
Hogan, Marshall D., 311 W. Main st., Boonton
Hubert, Antonio O., 131 E. Main st., Rockaway
Ivey, Evelyn P., Lake Valley rd., Morristown
Johnston, Julian F., 21 Van Doren av., Chatham
Kessler, Edward I., N.J. State Hosp., Greystone Pk.
King, Alden P., 400 W. Blackwell st., Dover
Klein, Milton, 45 E. Blackwell st., Dover
Knowles, Frederick E., 103 Church st., Boonton
Kossmann, Walter J., Long Valley
Krauss, Fletcher I., 407 Main st., Chatham
Kuite, George B., 435 Speedwell av., Morris Plains
Larson, Henry M., 35 Franklin st., Morristown
Lathrope, George H., 965 Broad st., Newark
Laudig, Guy H., 361 Speedwell av., Morris Plains
Loksa, Harold T., Army
Luippold, Eugene J., Jr., Army
Mathews, Raymond H., 186 South st., Morristown
McCluskey, Harry B., Morristown rd., Whippany
McMahon, Bernard C., 15 James st., Morristown
McMurray, George B., N. J. State Hosp.,Gr'st'nePk.
McMurtrie, William A., 20 Franklin st., Morristown
Melvin, Daniel G., N. J. State Hosp., Greystone Park
Mills, Clifford, 36 Maple av., Morristown
Musetto, Carmelo A., Navy
Navazio, Attilio, 29 DeHart st., Morristown
Nicoll, George L., Succasunna
Palazzo, William L., 135 Cornelia st., Boonton
Parry, Allen A., 46 Green Village rd., Madison
Parry, Antoinette R., 93 Greenwood av., Madison
Pinckney, Frank H., 186 South st., Morristown
Plume, Clarence A., Main st., Succasunna
Pollock, Samuel L., Army
Pottinger, William E., 6 Altamont court, Morristown
Prager, Bert A., 511 Main st., Chatham
Renna, Francis, 20 Morris av., Morristown
Rice, Franklin W., 184 South st., Morristown
Riley, Philetus H., 25 Hillcrest av., Madison
Rosenberg, Alvin A., Army
Rubens, Otto, Army
Rubin, Henry S., 11 High st., Morristown
Rubin, Samuel, Army
Ryman, Merlin T., 5 Dunbar st., Chatham
Saltus, Lloyd S., 16 Elm st., Morristown
Seward, Frederic H., 40 Green Village rd., Madison

Shanik, Morton J., Army
Sherman, Benjamin, Army
Sherman, Byron G., 52 Maple av., Morristown
Spencer, Alvan, 395 W. Blackwell st., Dover
Stage, Earl DeW., 37½ James st., Morristown
Talmage, William G., Main st., Succasunna
Taylor, Malcolm C., Army
Teller, Daniel W., Jr., 28 DeHart st., Morristown
Terreri, D. Joseph, Army
Teskey, Stanley, 10 Anderson rd., Bernardsville
Thomas, Thomas S., Jr., 18 Elm st., Morristown
Truax, Alfred J., Chester
Van Sickle, Albert W., Army
von Deilen, Henry O., 28 DeHart st., Morristown
Voorhies, Wm. S., Jr., N.J. State Hosp.,GreystonePk.
Voss, J. Landon, 21 Mt. Airy rd., Bernardsville
Wade, Francis A., 196 South st., Morristown
Ward, Albert J., 39 Elm st., Morristown
Warne, Merna M., N.J. State Hosp., Greystone Park
Weiss, Herman, Aurora Institute, Morristown
Williams, David P., Navy
Williams, Louis E., 80 Green av., Madison
Woodman, Charles B., 25 Ogden pl., Morristown
Young, George J., 60 Maple av., Morristown
Zimmerman, Robert F., 28 Wash'gton av.,Morrist'n

Number of Active Members and basis of representation, 125.

HONORARY MEMBERS

Baker, Augustus L., Dover
Coultas, Aldo B., Madison
Glazebrook, Francis H., Rumson
Gordon, Charles D., Mt. Arlington
Hampton, George R., Greystone Park
Haven, Samuel C., Morristown
Knowles, Frederick E., Boonton
Lathrope, George H., Newark
Mills, Clifford, Morristown
Plume, Clarence A., Succasunna
Prager, Bert A., Chatham
Seward, Frederic H., Madison

COURTESY MEMBER

Joy, Homer T., Morristown

OCEAN COUNTY (15)

Society organized October 28, 1903. Meets on second Wednesday of each month except July and August. Annual Meeting in May.

ACTIVE MEMBERS

Appleton, Ralph, Lincoln av., Point Pleasant
Bierach, Jules L., 120 Fourth st., Beach Haven
Buermann, Robert, 206 Madison av., Lakewood
Bunnell, Frederick N., 22 S. Main st., Barnegat
Carmona, L. Roberto, 141 Wood st., Tuckerton
Dodd, William E., Ocean st. & Bay av., Beach Haven
Falkinburg, LeRoy W., Army
Frazee, William H., Jr., 257 W. Main st.,Moorestown
Goldstein, Abraham, 404 Madison av., Lakewood
Graham, Richard B., Army
Green, Thomas J., New Egypt
Hayden, Walter G., 504 Main st., Toms River
Henriksen, J. Bruce, 422 River av., Point Pleasant
Herbener, Eugene G., 423 Third st., Lakewood
Hogan, James J., Navy
Ivory, Harry S., Richmond av., Point Pleasant
Joy, Ernest H., Navy
Lehmacher, Frank, 16 Central av., Lakewood
Menge, Carl H., 236 Washington st., Toms River
Nyvall, Pierre J., Barnegat
Obert, J. Edwin, Main st., New Egypt
Pecora, Carmine L., 212 Washington st., Toms River
Rinzler, Harvey, 614 Main st., Toms River
Sawyer, Blackwell, 109 Washington st., Toms River
Schneider, Clinton R., 125 N. Green st., Tuckerton
Sickel, Emanuel M., 318 Forest av., Lakewood
Szold, Norman F., 701 Princeton av., Lakewood
Taylor, Raymond A., 58 Madison av., Lakewood
Towbin, Adolph, 326 Third st., Lakewood
Witte, C. Norman, 422 River av., Point Pleasant

Number of Active Members and basis of representation, 30.

ASSOCIATE MEMBERS

Alpert, Sidney, 235 Fourth st., Lakewood
Gartlan, Bernard W., Main st., Toms River
Mitchell, Willis B., W. Washington st., Toms River

COURTESY MEMBER

Wentz, Irl B., Seaside Heights

HONORARY MEMBER

Hilliard, Joshua, Manahawkin

PASSAIC COUNTY (16)

Society organized January 14, 1844; Society chartered November 14, 1843. Meets on third Tuesday of each month except June, July and August. Annual Meeting in May.

ACTIVE MEMBERS

Achtentuch, Herman, 113 Sherman st., Passaic
Ackerhalt, Martin J., 408 Clifton av., Clifton
Adler, Fritz F., 162 Trenton av., Paterson
Allen, Arthur A., 365 Park av., Paterson
Allen, Edwin J., Army
Allen, James M., 26 Kent court, Passaic
Alpren, Bernard F., 34 Auburn st., Paterson
Andrews, Albert G. K., 75 Tulip st., Passaic
Apter, Abraham H., 45 Church st., Paterson
Ash, Frank W., 180 Carroll st., Paterson
Atwood, Edward A., 360 Park av., Paterson
Averbach, Jacob, Navy
Balles. Edward S., 392 Park av., Paterson
Barlow, Frank A., Navy
Barolsky, Benjamin, 811 E. 22nd st., Paterson
Barr, Joseph, 178 Market st., Paterson
Baxt, Sidney J., 544 21st av., Paterson
Becker, Frank F., 605 Ackerman av., Hohokus
Becker, George L., 646 E. 28th st., Paterson
Becker, Leo V., 69 Ward st., Paterson
Bender, Theodore, 666 Broadway, Paterson
Benjamin, Joseph F., 203 Godwin av., Ridgewood
Bergin, Joseph V., 315 Broadway, Paterson
Berk, M. David, 33 Bartholf av., Pompton Lakes
Berkhout, Peter G., 106 Haledon av., Prospect Park
Bernson, Samuel T., 33 Bartholf av., Pompton Lakes
Beshlian, Hagop K., 7 Lee pl., Paterson
Biczak, Arkad K., 311 Lexington av., Clifton
Blake, Albert J., Army
Bohl, Louis J., 320 Broadway, Paterson
Bongiorno, Henry D., 516 River st., Paterson
Bornstein, David, 566 Broadway, Paterson
Botbyl, Burt W., 927 Madison av., Paterson
Boylan, Lawrence B., 630 Main st., Paterson
Brancato, Peter, 93 E. 38th st., Paterson
Brancone, Alphonse M., Army
Brogan, Francis B., 234 E. 32nd st., Paterson
Bromberg, Charles B., 107 Lexington av., Passaic
Bronner, Alfred, 95 Jackson st., Passaic
Brooks, Sidney S., 380 12th av., Paterson
Budd, J. Reuben, 379 Clifton av., Clifton
Bullen, Victor E., 148 Hamilton av., Paterson
Butterfield, Arey A., 655 Main av., Passaic
Calligaro, Egildo A., 288 Parker av., Clifton
Capell, Harry H., 302 Broadway, Paterson
Capio, Mario D., 293 Broadway, Paterson
Carlisle, John H., 129 Prospect st., Passaic
Carlough, David J., 426 Ellison st., Paterson
Catanzaro, Francesco, 151 Jefferson st., Passaic
Chapman, Walter I., 944 Hudson Blvd., Bayonne
Chapnick, Maurice M., 715 Broadway, Paterson
Charney, William, Army
Cherry, Homer H., Valley View Sana., Paterson
Chester, Saul W., 634 Broadway, Paterson
Chilton, Forrest S., Navy
Chrisman, Irving, 423 Broadway, Paterson
Churg, Jacob, Army
Ciccone, Anthony C., 389 Grand st., Paterson
Clark, Orlo H., Navy
Close, Byron H., Hamburg Turnpike, Bloomingdale
Cogan, Henry, Box 3364, Daytona Beach, Fla.
Cohen, Julian, 592 E. 29th st., Paterson
Cohen, Louis, 257 Paulison av., Passaic
Cohen, M. Marvin, 582 E. 25th st., Paterson
Cohn, Isidor, 231 Lexington av., Passaic
Cole, L. Frank, 49 Garfield av., Clifton
Connolly, Joseph P., Hamilton & Ward sts., Paters'n
Conserva, Peter V., Navy
Cortese, Alvin E., 26 Ward st., Paterson
Cotton, Norman T., 219 Graham av., Paterson
Cremens, John F., 144 Carroll st., Paterson
Crescente, Fred J., 827 Madison av., Paterson
Crounse, David R., 84 Broadway, Passaic
Curtis, A. Maurice, 445 Van Houten st., Paterson
Davis, A. Hobson, Paterson General Hosp., Paterson
Dawson, Harry, 618 E. 24th st., Paterson
DeBell, Peter J., 65 Summer st., Passaic
DeGrace, Francis H., 344 Gregory av., Passaic
Deich, Samuel R., 162 Lexington av., Passaic
Delario, Anthony J., 316 Broadway, Paterson
Del Mauro, Alphonse, 460 Park av., Paterson
DeMattia, Michael, 71 Ward st., Paterson
Denison, Ward C., 264 Lotte rd., Ridgewood
DeRosa, Armand, Army
Desmet, Victor F., 324 Broadway, Paterson
De Yoe, Leon E., Navy
Dingman, Norman M., 330 Broadway, Paterson
Doktor, David, 415 Park av., Paterson
Donnelly, Joseph E., 445 Market st., Paterson
Douglass, Stephen A., Valley View Sana., Paterson
Dow, Robert F., Army
Drake, Daniel E., Union Valley rd., Newfoundland
Duncan, Owsley B., 654 East 28th st., Paterson
Dunning, Walter L., 533 River st., Paterson
Dwyer, Henry E.. 261 Madison st., Passaic
Dwyer, William A.. 99 Park av., Paterson
Edlkraut, Edward C., 320 Lexington av., Clifton
Ehrenfeld, Edward, 185 Lexington av., Passaic
Ehrenfeld, Irving, 185 Lexington av., Passaic
Eisemann, Jerome S., 38 Main st., Butler
Ekings, Frank P., 221 Broadway, Paterson
Esposito, Anthony L., 478 Clifton av., Clifton
Farkas, Gustav, 255 Harrison st., Passaic
Feigenoff, Israel, 271 Park av., Paterson
Feliciano, Vincent, 33 N. Eighth st., Hawthorne
Fenster, Morton N., 202 Lexington av., Passaic
Fenwick, John R., 196 Lakeview av., Cilfton
Ferrary, Paul B., 232 Totowa rd., Totowa
Fielding, William M., 15 Waldwick av., Waldwick
Fiering, Abraham M., Pompt'n Tnpk., Mount'n View
Fishbein, Elliot, Army
Fisher, Samuel, 808 Madison av., Paterson
Flitcroft, William, 510 River st., Paterson
Fortay, Steven O., 474 Park av., Paterson
Fortuin, Floyd, 325 N. 11th st., Paterson
Fraulo, Louis, 347 Crooks av., Clifton
Freedman, Jacob S., 178 Hamilton av., Passaic
Friedman, Edna C., 584 Broadway, Paterson
Gallardo, Augustin, 61 Lakeside av., Pompton Lakes
Gallo, James S., 594 Broadway, Paterson
Garnett, Robert, 204 Madison st., Passaic
Geiger, Harold C., Main st., West Milford
Gellman, William B., 163 Valley Blvd., Wood-Ridge
Gelman, Sidney, 399 E. 34th st., Paterson
Gershenson, Wilbur M., 130 W. 47th st.. N. Y. C.
Giambra, Sante M., 440 Park av.. Paterson
Ginsburg, Samuel, 227 Paulison av.. Passaic
Glasgow, Thomas M., 120 Passaic av.. Passaic
Gochman, Harry M., 166 Hamilton av.. Paterson
Goldenberg, Raphael R., 588 E. 27th st., Paterson
Golding, Harry N.. 180 Carroll st.. Paterson
Goldstein, Edward W., 356 Park av.. Paterson
Gordon, Samuel, 540 Park av., Paterson
Gormley, Cyrus M.. 15 Kiel av.. Butler

Gould, John H., 92 Monte Vista av., Ridgewood
Graeter, F. Albert, 141 Broadway, Passaic
Graham, Archibald F., 42 Park av., Paterson
Graham, Theodore K., 279 Park av., Paterson
Greengrass, Jacob J., 146 Broadway, Paterson
Greenwell, Albert W., 6 S. Brookwood dr., Montclair
Guarraia, Joseph, Army
Gurnee, Quinby D., 168 Diamond Br. av., Hawthorne
Hall, Wayne W., 240 Prospect st., Ridgewood
Halnan, John J., Jr., 631 Madison av., Paterson
Hambright, Arthur M., Wyckoff av., Ramsey
Harreys, Charles W., 153 Prospect st., Ridgewood
Hatem, Elias J., 1046 Main st., Paterson
Hayman, Irving R., 681 Broadway, Paterson
Hillmann, Frederick C., 64 Hamilton st., Paterson
Hollingsworth, H. Hale, 86 First st., Clifton
Holmes, Thomas J. E., 151 Fair st., Paterson
Holster, Stephen G., 951 Madison av., Paterson
Holt, Herman H., 576 Broadway, Paterson
Hughes, J. Vernon, P. O. Box 454, Passaic
Ianacone, John A., 310 Fifth av., Paterson
Iraggi, James V., Army
Izenberg, David, 555 E. 29th st., Paterson
Jaffe, Hyman, 149 Broadway, Passaic
Jahn, Albert G., 657 Main av., Passaic
Jani, Frank F., 297 Lexington av., Passaic
Jarmulowsky, Harry, 181 E. 33rd st., Paterson
Jehl, Joseph R., 59 Harding av., Clifton
Joelson, Dora, 485 Park av., Paterson
Joelson, Morris S., 577 Broadway, Paterson
Joffe, Philip M., 556 E. 28th st., Paterson
Joffe, Sidney H., 556 E. 28th st., Paterson
Johnsen, Sigurd W., 149 Prospect st., Passaic
Joseph, Morris, 271 Lexington av., Passaic
Katz, Harry, 494 Park av., Paterson
Keating, Charles A., 177 Ellison st., Paterson
Keating, Joseph M., Army
Keller, Michael L., Army
Kelley, Ray H., Box 46, Pequannock
Kennedy, A. Andrew, Navy
Kennedy, Eugene T., 413 Wanaque av.,PomptonLks.
Keppler, Charles, Jr., 723 Allwood rd., Clifton
Kim, Gay B., 703 Main st., Paterson
Kinney, Burton O., 41 Lincoln av., Little Falls
Kleiner, Samuel, 162 Hamilton av., Paterson
Kleinmann, Eberhart H., 560 Broadway, Paterson
Klughaupt, Dorothy K., 49 Passaic av., Passaic
Koenig, Bertram, 311 Broadway, Paterson
Koerber, George, 136 Prospect st., Passaic
Kovaleski, Walter A., 77 Market st., Passaic
Kovin, Abraham, 123 Lexington av., Passaic
Krieger, George, Army
Krugman, Benjamin M., 438 Park av., Paterson
Laauwe, Harold W., 360 Park av., Paterson
Landaw, Louis, 631 E. 26th st., Paterson
Lawrence, Arthur C., Main st., Lincoln Park
Lawrence, Elias D., P. O. Box 1751, Paterson
Leach, John E., 17 Bancroft pl., Fair Lawn
Lee, Frederick P., 606 E. 27th st., Paterson
Lemay, Albert T., Navy
Levine, David B., 647 Broadway, Paterson
LeVine, Israel, 215 Broadway, Paterson
Levine, Sidney C., 459 Park av., Paterson
Levinsohn, Sandor A., 656 East 29th st., Paterson
Levy, David, 268 Park av., Paterson
Levy, Herman, 219 Lexington av., Passaic
Liana, Stephen M., Army
Lima, John G., 292 Broadway, Paterson
Linares, A. Carfi, 208 Market st., Paterson
Lipton, Louis, 67 Passaic av., Passaic
Lobsenz, Nathan P., 294 Broadway, Paterson
Lomauro, James R., 184 Lexington av., Passaic
London, Jules R., 340 Paulison av., Passaic
London, Leslie, 119 Lexington av., Passaic
Low, Donald B., 529 Broadway, Paterson
Lucent, S. Bell, 2 First av., Little Falls
Luksteid, Casimir J., 326 Park av., Paterson
MacAlister, William W., 171 Carroll st., Paterson
MacGahan, Wm. H., 516 Wanaque av., Pompt'nLks.
MacGregor, Allan W., 379 Ellison st., Paterson
MacGuffie, Robert N., 657 Main av., Passaic
Mackler, Meyer E., 627 E. 24th st., Paterson
Maclay, Joseph A., 239 Broadway, Paterson
Maffongelli, Joseph A., 494 River st., Paterson
Magnes, Max, 660 E. 23rd st., Paterson
Manzione, Frank A., 500 Union av., Paterson
Maps, Howard L., Country Club Estates, Budd Lake
Marini, Dominick, 40 Henry st., Passaic
Markel, Albert G., 450 Park av., Paterson
Markowitz, Louis, 380 Park av., Paterson
Marrocco, William A., 418 Park av., Paterson
Martin, Theodore, Army
Masucci, Alberico, 128 Carroll st., Paterson
Matthews, Leonard M., 655 Main av., Passaic
Mazzarella, Carlo, 237 Broadway, Paterson
McBride, Andrew F., Jr., 655 Broadway, Paterson
McCarthy, George L., 506 Union av., Paterson
McCue, John B., 118 Lenox av., Pompton Lakes
McDonald, Richard J., 80 Park av., Paterson
McPherson, Malcolm E., 141Diam'd Br.av.,H'wth'rne
Meier, William U., 1062 Ringwood av., Haskell
Meloney, Lester F., 156 Second st., Clifton
Meneve, Alfred D., 373 Broadway, Paterson
Meyers, Francis R., Navy
Michelson, Henry, 258 Park av., Paterson
Missonellie, William, 404 Lafayette av., Hawthorne
Mitchell, Charles R., 311 Broadway, Paterson
Monaloy, Morris A., 26 Barry pl., Passaic
Morici, Theodore, 80 Howe av., Passaic
Morrill, James P., Jr., 310 Broadway, Paterson
Moscoe, Harry A., 320 Broadway, Paterson
Mott, Joseph E., 426 Park av., Paterson
Murn, Charles J., 48 Smith st., Paterson
Neer, William, 308 Woodside av., Ridgewood
Nemirow, Martin, 234 Lexington av., Passaic
Nesbitt, Elizabeth, N. Jersey Tr'n'g Sch'l,LittleFalls
Norris, Alfred W., 123 Prospect st., Ridgewood
Norval, Wm. A., 752½ 32nd av., N., St.P't'rsb'g,Fla.
Notkin, Meyer, 559 Broadway, Paterson
Noto, Philip, 158 Washington pl., Passaic
Nye, Howard H., 174 Carroll st., Paterson
O'Brian, Dennis M., 154 Lexington av., Passaic
O'Brian, Jeremiah H., 661 Main av., Passaic
Ogden, Michael A., 20 Grove st., Passaic
Okin, Irving, 165 Passaic av., Passaic
Opper, Philip, 606 E. 26th st., Paterson
Oram, Joseph H., 495 Broadway, Paterson
Palma, Nicholas, 116 17th av., Paterson
Palmer, Francis R., 220 Lexington av., Passaic
Paris, William, 518 E. 25th st., Paterson
Pasternack, Elroy, 255 Harrison st., Passaic
Patella, Fulvio, 324 Broadway, Paterson
Pernetti, Anthony M., 245 The By Way, Ridgewood
Phelps, James E., 203 Park av., Paterson
Piasecki, Chester A., Army
Piller, Jacob, 213 Broadway, Paterson
Pink, Solomon H., 21 High st., Butler
Pfinke, Fritz W., 265 Gregory av., Passaic
Polizzotti, Joseph L., 193 Park av., Paterson
Pollock, Theodore, 27 Belmont av., Garfield
Polowe, David, 555 E. 27th st., Paterson
Prince, Robert A., 567 Broadway, Paterson
Provisor, Benjamin, 271 Lexington av., Passaic
Raab, Michael, Army
Radest, Louis J., 347 Broadway, Paterson
Randazzo, Anton P., 82 Prospect st., Passaic
Rauschenbach, Paul E., Jr., 239 Broadway, Paterson
Reading, H. Eugene, 535 E. 29th st., Paterson

Reeves, Ernest, 195 Lexington av., Passaic
Reilly, Thomas F., 127 Union av., Clifton
Reiner, David N., Army
Reinhorn, Abraham J., 297 Broadway, Paterson
Riccobono, Cosmo S., 334 Park av., Paterson
Rinzler, Harry G., 127 Van Houten av., Passaic
Ritter, John J., Box 86, Plainfield, Mass.
Robertson, Eugene V., 339 Lafayette av.,Hawthorne
Roemer, Jacob, 591 E. 27th st., Paterson
Romano, Michael J., 2 Arlington pl., Radburn
Ross, Peter W., Army
Roy, Joseph N., 95 17th av., Paterson
RuBacky, Joseph F. A., 61 Passaic av., Passaic
Ruocco, William B., 416 River st., Paterson
Russell, Charles B., 119 Hamilton av., Paterson
Sabarese, Theodore C., 122 Marsellus pl., Garfield
Saco, Louis S., 922 Main st., Paterson
Saffron, Morris H., 292 Paulison av., Passaic
Sala, Aldo W., 172 Randolph av., Clifton
Salter, Kent, Valley View Sana., Paterson
Salzman, Nathan, 714 Broadway, Paterson
Sanfacon, Thomas A., 340 Park av., Paterson
Santangelo, Emil L., 313 18th av., Paterson
Sarokhan, Joseph, 771 Madison av., Paterson
Schafer, Marguerite A., 298 D'mondBr.av.,H'wth'rne
Schefrin, Alexander E., 235 Lexington av., Passaic
Schlossberg, Ezra, 175 Broadway, Passaic
Schubert, Roy R., 466 Park av., Paterson
Schultz, Augustin M., 379 Union av., Paterson
Schwartz, Jacob R., 7-06 Fairlawn av., Fair Lawn
Schwartz, William, 224 Lexington av., Passaic
Schwartzberg, Frederick I., Army
Schwarz, Julianna L., 57 Passaic av., Passaic
Scielzo, Nicholas F., 369 Park av., Paterson
Scribner, Chas. H., R.F.D.1, Hamb'g Tnpk.,Pat'ers'n
Shapiro, David, 707 Broadway, Paterson
Shapiro, Louis G., 375 Broadway, Paterson
Shechtman, Abraham, 37 Grove st., Passaic
Sheft, Matthew J., 112 Lexington av., Passaic
Shinefeld, Maurice A., 669 Broadway, Paterson
Shipman, Meyer P., 575 Broadway, Paterson
Shippee, James N., 648 Ringwood av., Wanaque
Shulman, Abraham, 528 E. 29th st., Paterson
Siciliano, Thomas, 6 Clinton av., Clifton
Silverman, Irving A., 260 Dayton av., Clifton
Simkin, Abraham, 232 Broadway, Passaic
Simon, Julius J., Army
Simon, Philip H., 174 Columbia av., Passaic
Slaff, Florence, 16 Grove st., Passaic
Sloan, Samuel L., 182 Belmont av., Paterson
Small, Louis, 23 Passaic av., Passaic
Smith, Elroy W., 309 E. DeLido dr., Miami B'ch,Fla.
Smith, Leon A., 655 Main av., Passaic
Sobel, I. Jerome, 136 Broadway, Passaic
Stark, Jacob, 645 Broadway, Paterson
Stein, Harold M., 227 W. Broadway, Paterson
Stein, Harriet N., 620 Ridge rd., Lyndhurst
Steinberg, Benjamin L., Army
Stern, Morris H., Army
Stier, Howard W., 164 Jefferson st., Passaic
Stokes, James S., 32 Main st., Little Falls
Stoltz, Raymond R., 23 Passaic av., Passaic
Stouter, Francis L., Army
Sucoff, Moses C., 158 Hamilton av., Passaic
Sullivan, William M., Jr., 43 Passaic av., Passaic
Surgent, George W., 168 Clifton av., Clifton
Sutherland, William W., 400 Broadway, Paterson
Szymanski, John J., 616 Main av., Passaic
Taber, Leslie R., 292 Broadway, Paterson
Tarta, Ciro S., 641 E. 18th st., Paterson
Teichholz, Max H., 112 Howe av., Passaic
Tell, M. Edward, 249 Lexington av., Passaic
Thomas, Irene O., Navy
Thomas, Leon H. S., 631 E. 22nd st., Paterson
Thompson, Edward C., 373 Park av., Paterson
Thorne, William P., 254 Main st., Butler
Thron, Leopold E., 586 E. 29th st., Paterson
Todd, Francis H., 83 Auburn st., Paterson
Tomkins, William, 105 Fairmount rd., Ridgewood
Tweddel, George K., 239 Broadway, Paterson
Udinsky, Hyman J., 21 Grove st., Passaic
Vanderbeck, James J., Franklin av., Ridgewood
Vanderbeek, Andrew B., 174 Broadway, Paterson
Vanderbeek, Frank B., Army
Vander Clock, Cornelius, 178 Gregory av., Passaic
Van Eerde, Albert, 339 Lafayette av., Hawthorne
Van Schott, Gerard J., Jr., 245 Lex'gton av., Passaic
Van Winkle, John S., 297 Broadway, Paterson
Vermeulen, Abram, 344 Haledon av., Prospect Park
Vernaglia, Anthony P., 418 Lincoln av., Hawthorne
Visceglia, Frank R., 99 Gregory av., Passaic
Vosburgh, Fred, 53 Passaic av., Passaic
Vreeland, Ralph J., 266 Van Houten st., Paterson
Walker, Harold G., Everett av., Wyckoff
Wallace, Marc J., 165 Lakeview av., Clifton
Walton, Gordon G., 17 Church st., Paterson
Warburton, Jack C., Army
Ward, Albert H., 404 Totowa av., Paterson
Warren, David E., 233 Gregory av., Passaic
Warren, Earl L., 266 Van Houten st., Paterson
Warren, Jacob, 308 18th av., Paterson
Wassing, Hans, 695 Broadway, Paterson
Weinert, Henry V., 128 Market st., Passaic
Weintraub, William L., 400 Broadway, Paterson
Weisman, Stephen L., Army
Westerhoff, Peter D., 51 Highland av., Midland Park
White, Richard E., Grandview av., R. D., Midl'dPark
Williams, Hiram, P. O. Box 272, Passaic
Winters, Walter M., 288 Broadway, Paterson
Wishnack, Meyer, 318 Broadway, Paterson
Wolf, Erich, 43 Grove st., Passaic
Wolf, Israel J., 231 East 31st st., Paterson
Wolfson, Harry, 356 Park av., Paterson
Wry, Dean A., 234 Dayton av., Clifton
Yachnin, Samuel C., 32 Ridge rd., Lyndhurst
Yager, J. Allen, 420 Broadway, Paterson
Yates, John S., 414 Ellison st., Paterson
Yeaw, Ralph C., 180 Carroll st., Paterson
Yolken, Harry, 246 E. 31st st., Paterson
Zalewski, Irene J., 181 Paulison av., Passaic
Zick, Clara U., 60 Highland rd., Glen Rock
Zuckerman, David E., 568 Broadway, Paterson

Number of Active Members and basis of representation, 404.

ASSOCIATE MEMBERS

Carusi, Leonardo G., 337 Park av., Paterson
Chudzik, Edward W., Army
Cichon, Elmer J., 10 Samuel av., Clifton
Friedmann, Gustav, 351 Totowa av., Paterson
Goldman, Sol B., Navy
Golish, Harry L., 425 15th av., Paterson
Gordon, William, 648 Ringwood av., Wanaque
Grossbard, Paul, 211 Lexington av., Passaic
Kaletkowski, Marion F., Army
Korman, Arnold, 24 Day st., Clifton
Lang, Richard E., 297 Howard av., Passaic
Legg, George E., 666 Broadway, Paterson
Nussbaum, Nathan, Army
Palmeri, Anthony F., 47 Rowland av., Clifton
Reinkraut, Arthur D., 175 Broadway, Passaic
Rogers, James A., Navy

Salerno, Louis, 973 Van Houten av., Clifton
Schleifer, Arnold, 10-04 River rd., Fair Lawn
Scovern, Louis, Army
Silver, Michael W., 718 E. 25th st., Paterson
Yoskowitz, Benjamin, Army
Zigarelli, Joseph F., 273 E. 18th st., Paterson

COURTESY MEMBERS

Della Penna, Samuel J., Army
Pearlman, Saul J., Army
Trilling, Leonard J., Army

HONORARY MEMBERS

Bergin, Joseph V., Paterson
Bullen, Victor E., Paterson
Crounse, David R., Passaic
Duncan, Owsley B., Paterson
Dunning, Walter L., Paterson
Flitcroft, William, Paterson
MacAlister, William W., Paterson
Maclay, Joseph A., Paterson
Neer, William, Ridgewood
Norval, William A., St. Petersburg, Florida
Ritter, John J., Plainfield, Mass.
Scribner, Charles H., Paterson
Todd, Francis H., Paterson
Vanderbeek, Andrew B., Paterson
Ward, Albert H., Paterson
Yates, John S., Paterson

SALEM COUNTY (17)

Society organized May 4, 1880. Meets on the third Friday of each month, September to May, inclusive. Annual Meeting in April. Social Meeting in May.

ACTIVE MEMBERS

Bramble, Halsey S., Front & Chestnut sts., Elmer
Caggiano, John D., 165 W. Main st., Penns Grove
Chesler, Maurice, 124 W. Broadway, Salem
Cox, J. Robert, Army
Davison, C. Spencer, 7 Chestnut st., Salem
Davison, Wilbur S., 13 N. Broadway, Pennsville
Dunn, John S., Navy
Evans, Edgar E., 12 Ziegler Tract, Penns Grove
Fleming, Charles L., 42 W. Main st., Penns Grove
Green, David W., 69 Market st., Salem
Hilliard, William T., 105 Market st., Salem
Hummel, Lee C., 109 W. Broadway, Salem
Jonas, August, 328 E. Broadway, Salem
Lipkin, Isadore, 157 W. Main st., Penns Grove
Lummis, Clarence P., 40 Delaware av., Penns Grove
Mackes, Claude B., 48 N. Main st., Woodstown
Mason, Alvin S., 26 Olive st., Salem
Miller, Lewis H., 37 S. Main st., Woodstown
Miller, William H., 33 S. Main st., Woodstown
Morris, Charles W., 119 Fourth st., Carneys Point
Parker, Albert F., Army
Perry, Frank L., East av., Woodstown
Prigger, Edward R., 21 Delaware av., Penns Grove
Savage, Charles L., 20 Ziegler Tract, Penns Grove
Sayers, Francis P., Army
Silverman, R. Louis, 21 W. Main st., Penns Grove
Suter, Harry F., 49 W. Main st., Penns Grove
Thomas, Claude W., 28 East av., Woodstown
Zappala, John, 47 W. Main st., Penns Grove

Number of Active Members and basis of representation, 29.

SOMERSET COUNTY (18)

Society organized May 21, 1816. Meets on second Thursday evening of each month except July, August and September. Annual Meeting in June. Dinner Meeting in October.

ACTIVE MEMBERS

Adams, Rayford K., Lakeside Lodge, Skillman
Allegrante, Anthony J., W'sh'gt'nVal.rd.,M'rtinsville
Ambrose, Robert R., Navy
Barbour, George E., 118 W. High st., Somerville
Blank, Samuel, Army
Borow, Henry, 507 Church st., Bound Brook
Borow, Louis S., Army
Borow, Maurice, 507 Church st., Bound Brook
Brittain, Elmore G., 4 E. High st., Bound Brook
Carlucci, Angelo M., N. J. State Village, Skillman
Cooley, Justus H., II, Army
Craig, Henry A., 315 William st., Somerville
Crawford, John W., Army
Douglass, William C., 15 Olcott av., Bernardsville
Dresel, Irmgard, Mine Brook rd., Far Hills
Edelberg, Sidney S., 403 E. High st., Bound Brook
Ely, Lancelot, 128 W. High st., Somerville
Falcone, Nicholas A., 68 Watchung av., N. Plainfield
Field, Frank L., Far Hills
Flint, Edgar T., 44 E. Somerset st., Raritan
Fritts, Lewis C., 118 West End av., Somerville
Galgoczy, Julius, Manville
Gentile, Ernest R., 125 Hamilton st., Bound Brook
Gray, W. Burritt, 121 Somerset st., N. Plainfield
Greenberg, George A., 195 W. High st., Somerville
Guertin, Diomede, N. J. State Village, Skillman
Heaton, Stuart C., Navy
Hegeman, Runkle F., 161 W. High st., Somerville
Hemingway, Norman L., Army
Hird, Emerson F., 118 E. Maple av., Bound Brook
Hochheimer, Arthur, 417 Somerset st., Bound Brook
Husted, Samuel H., Neshanic Station

Hyer, Godfrey S., W. High st. & Mtn.av.,Somerville
Jones, William F., N. Bridge st., Somerville
Kay, Clarence R., Main st., Peapack
Klompus, Irving, Navy
Knight, Augustus S., Far Hills
Lawton, A. Anderson, Coast Guard
Levy, Abram, 1120 W. Seventh st., Plainfield
Liddell, Raymond N., Leonardo
Loeb, William A., Army
Marcus, Bernard, Garden Apts., Bound Brook
Misko, Albert, 117 Westervelt av., N. Plainfield
Morris, Nathan, Army
Pearson, Theodore A., White House
Pigott, Albert W., N. J. State Village, Skillman
Pitman, Mason W. H., 17 Ross st., Somerville
Pogoloff, Samuel H., 68 N. First av., Manville
Reale, Nicholas P., Brooks Blvd., Manville
Renner, Clara C., Blawenburg
Rossi, Bartolomeo, 325 Vosseler av., Bound Brook
Rossi, Gene, 79 Talmadge av., Bound Brook
Russo, Dominic T., 51 E. Somerset st., Raritan
Sargent, Eva R., 121 Myrtle av., North Plainfield
Schram, William S., 252 Bergen av., Kearny
Spaldo, John L., Army
Thornton, P. John S., Army
Tolomeo, Martin E., Army
Wallach, Bernard, Army
Weitz, Paul, Veterans Administration, Lyons
Wolfram, Julius, Army
Wolfsie, Jacob H., Calco Chemical Co., Bound Brook
Young, James L., 68 Mountain av., Somerville

Number of Active Members and basis of representation, 63.

SUSSEX COUNTY (19)

Society organized August 22, 1829. Regular meetings in February, May, September and December at time, place and date designated by President and Secretary.

ACTIVE MEMBERS

Aitken, Herbert M., Navy
Bergman, Ewald H., 44 Bank st., Sussex
Boyd, William B., Jr., N. J. Zinc Co., Franklin
Braun, David C., 51 Trinity st., Newton
Burn, Victor E., 27 Trinity st., Newton
Caleca, Jack J., Army
Cartisser, Joseph J., Stanhope
Coleman, Joseph G., Hamburg
Drake, Leo B., 47 Main st., Franklin
Eddy, Lester R., 40 Bank st., Sussex
Hawke, Edward K., Army
Hill, Dean F., Sussex
Johnson, George F., Branchville
Kirschner, Martin I., Vernon
Landes, Edwin W., Stillwater
Longnecker, John E., Jr., Sparta
Lushear, Frank H., Branchville
McCall, Jesse, 9 Linwood av., Newton
McVeigh, Charles J. D., Netcong
Morrison, Frederick H., 61 High st., Newton
Pellet, Thomas L., Hamburg
Roy, Bert W., 25 Hamburg av., Sussex
Schmidt, Clifford M., 81 Main st., Newton
Scott, Frederick J., 1 Oak st., Franklin
Spencer, James H., Jr., Newton
Spurgeon, Dorsett L., 19 Church st., Newton
Stewart, Katherine E., Railroad av., Ogdensburg
Vermes, Leslie, 380 Rutherford av., Franklin
Weinstein, Robert A., 214 Spring st., Newton
Weiser, Edward H., 40 Bank st., Sussex

Number of Active Members and basis of representation, 30.

UNION COUNTY (20)

Society organized June 7, 1869. Meets on second Wednesday of September, November, January, March, April, and May. Annual Meeting in April.

ACTIVE MEMBERS

Abel, Henri E., 339 Union av., Elizabeth
Abramson, Solomon, 1587 Irving st., Rahway
Ackerman, Arthur F., 129 Summit av., Summit
Allen, Samuel L., Army
Anson, Leon J., 400 Center st., Garwood
Apfelbaum, Frederick M., 290 Potter pl.,Weehawken
Armstrong, Lorrimer B., 121 S. Euclid av., Westfield
Arthur, Frances H., 138 Westfield av., Elizabeth
Austin, Thomas R., Army
Babbitt, Hugh M., Jr., 950 Park av., Plainfield
Baker, Raymond D., 52 De Forest av., Summit
Banker, George T., 1145 E. Jersey st., Elizabeth
Barberio, A. Arthur, 1337 Orange av., Union
Baron, Leo E., 26 Prospect pl., North Plainfield
Baruch, Hilde, 202 Stiles st., Elizabeth
Baruch, Rudolf J., 202 Stiles st., Elizabeth
Battaglia, Richard S., 323 Third av., Roselle
Bechet, Paul E., 1364 North av., Elizabeth
Beisler, Lawrence G., 1528 N. Broad st., Hillside
Bender, Dorothea A., 61 DeHart pl., Elizabeth
Bensley, Maynard G., 129 Summit av., Summit
Berenson, Samuel J., 1012 E. Jersey st., Elizabeth
Berman, Leonard M., 128 Summit av., Summit
Berman, Sol, 351 Rahway av., Elizabeth
Bernstein, Benedict J., 434 E. Front st., Plainfield
Berry, C. Hartley, 129 Summit av., Summit
Biber, David, 2066 Emerson av., Union
Birrell, Russell G., 554 Westminster av., Elizabeth
Bishop, Carl, 831 Madison av., Plainfield
Black, Max S., 1320 St. George av., Linden
Blair, Thomas D., 414 Park av., Plainfield
Blatt, David, 960 Madison av., Elizabeth
Bloch, Harry, 613 N. Broad st., Elizabeth
Blumberg, Jack, 504 Westminster av., Elizabeth

Blythe, Rowland P., 30 Springfield av., Cranford
Boehm, Herbert, 804 E. Jersey st., Elizabeth
Bolanowski, Kasimier J., Army
Booth, Walter S., 744 Rahway av., Elizabeth
Bourns, Edward G., 203 S. Euclid av., Westfield
Bowles, Harry H., 36 Woodland av., Summit
Boyd, Robert P., 210 Martine av., S., Fanwood
Boyer, Paul K., 129 Summit av., Summit
Boyes, James G., 1326 Chetwynd av., Plainfield
Braun, Edgar M., Army
Braunwarth, Robert J., 555 S. Broad st., Elizabeth
Breslow, Alexander E., 930 Pierpont st., Rahway
Brethwaite, Samuel H., Jr., 129 Summit av., Summit
Brokaw, Christopher A., 1405 North av., Elizabeth
Brown, Frank H., Jr., 327 Chestnut st., Roselle Park
Brown, L. Greeley, 173 Madison av., Elizabeth
Brown, William H., 501 First av., Elizabeth
Buchanan, Robert W., 129 Summit av., Summit
Buffey, Walter H., 19 Oakwood pl., Elizabeth
Burritt, Norman W., 30 Beechwood rd., Summit
Butenas, Joseph J., 300 First av., Elizabeth
Callahan, Edward J., 124 St. Paul st., Westfield
Cannis, John P., 1019 Park av., Plainfield
Canright, Cyril M., 34 Springfield av., Cranford
Cantini, Raphael S., 727 Watchung av., Plainfield
Card, Charles F., 144 W. Milton av., Rahway
Cardinale, Pasquale F., 654 E. Jersey st., Elizabeth
Carlin, Edward J. M., 1423 Irving st., Rahway
Carlisle, J. Mallory, 550 Hillcrest av., Westfield
Carpenter, Cedric C., 97 Hobart av., Summit
Carsley, Sidney H., 19 Holly st., Cranford
Casey, Robert B., 104 W. Milton av., Rahway
Casilli, Arturo R., 618 Newark av., Elizabeth
Castaldo, Neil, 103 Lincoln av., E., Cranford
Chaiken, Louis H., 1024 E. Jersey st., Elizabeth
Chapman, Otis P., 125 Broad st., Elizabeth
Childers, Robert J., 604 Park av., Plainfield
Chodosh, Maurice A., 606 Roosevelt av., Carteret
Cole, Walter H., Jr., 1060 E. Jersey st., Elizabeth
Comunale, Anthony R., 1709 Irving st., Rahway
Conway, James V., 428 Elmora av., Elizabeth
Coplin, George J., 528 E. Jersey st., Elizabeth
Corbusier, Harold D., 612 Park av., Plainfield
Cox, William T. R., 345 S. Broad st., Elizabeth
Crabtree, Loren H., 505 Jersey av., Elizabeth
Crane, Norman T., 1025 Sleepiy Hollow lane,Plainf'd
Cronin, Francis J., 730 South st., Elizabeth
Dalberg, Walter, 500 Cherry st., Elizabeth
Davidson, E. Norwell, 102 East Elm st., Linden
Davis, F. Cleveland, 129 Summit av., Summit
Davis, Stanton H., 212 E. Seventh st., Plainfield
Day, Willis B., 407 E. Seventh st., Plainfield
DeCesare, Ferdinand J., 500 Walnut st., RosellePark
Decker, Charles T., 275 Orchard st., Westfield
Demarest, Gerald B., 505 E. Broad st., Westfield
Dengler, Henry P., 260 Morris av., Springfield
Deutsch, Nathan S., 223 E. Fifth st., Plainfield
Diamond, J. George, 512 W. Front st., Plainfield
Doggett, E. Hugh, 805 Park av., Plainfield
Doherty, William, 830 N. Wood av., Linden
Dolsky, Irving, 509 N. Wood av., Linden
duBusc, L. C. Victor, 399 Westfield av., Elizabeth
Dunn, H. Irving, Army
Dupuy, Jean G., 850 Jersey av., Elizabeth
Durrah, Fred F., 310 Plainfield av., Plainfield
Dwoyer, Leon C., 420 N. Wood av., Linden
Eason, Samuel W., 48 De Forest av., Summit
Edgar, Malcolm S., 129 Summit av., Summit
Ehrlich, Max, 721 N. Broad st., Elizabeth
Esty, Geoffrey W., 629 E. Broad st., Westfield
Evans, Joseph O., 727 N. Wood av., Linden
Falconer-Slater, Kath., Four Winds, Kotonah, N. Y.
Feleppa, Edward E., 618 Springfield av., Summit
Fiedler, Michael J., 247 Crawford ter., Union
Figliolino, Francis, 272 W. Milton av., Rahway
Fink, Stanley J., 268 E. 3rd av., Roselle
Fitch, Thomas S. P., Navy
Fort, William B., 147 E. Seventh st., Plainfield
Foster, Frank L., 320 Springfield av., Cranford
Franklin, Joseph E., 191 North av., Hillside
Franklin, Lewis J., 149 Jean ter., Union
Freeman, Ray M., 2011 St. Georges av., Rahway
Friedburg, George H., 1108 Anna st., Elizabeth
Frohwein, Ida H., 125 Morristown rd., Elizabeth
Gadomski, Casimir F., Army
Gallaway, George E., 163 W. Milton av., Rahway
Gannon, Joseph M., 149 Crescent av., Plainfield
Geary, Paul, 909 Park av., Plainfield
Gelber, Isaac, 2052 Morris av., Union
Gerendasy, Julius, 956 E. Jersey st., Elizabeth
Gibb, Alice S., 339 Union av., Elizabeth
Giglio, Alphonsus S. V., 626 Elizabeth av., Elizabeth
Gilpin, Fletcher, 118 North av., W., Cranford
Gittelman, Morton, 879 Newark av., Elizabeth
Glaser, Emanuel, 360 Linden av., Elizabeth
Glass, Benjamin E., 609 Watchung av., Plainfield
Glass, Harry L., 1009 Park av., Plainfield
Glassner, Frank, 308 Chestnut st., Roselle
Glasston, Hyman M., 628 N. Wood av., Linden
Golden, William M., 757 Pierpont st., Rahway
Goldfield, Harold H., 225 E. Jersey st., Elizabeth
Goldmacher, Herman B., 113 Elmora av., Elizabeth
Goldstein, Herman H., 318 W. Jersey st., Elizabeth
Gonczy, Edward J., 420 Jersey av., Elizabeth
Grant, William E., 1370 Morris av., Union
Greenberg, Max, 29 W. Henry st., Linden
Griesemer, Z. Lawrence, 1145 E. Jersey st., Elizab'th
Griswold, Merton L., Jr., 1415 Prospect av., Plainf'd
Guidi, Guido M., 212 Christine st., Elizabeth
Hall, Winthrop H., 400 Elm st., Westfield
Hallock, Wilton J., 650 Springfield av., Summit
Hamley, John J., 153 Second st., Elizabeth
Hansen, Harry, 916 Park av., Plainfield
Hanson, Carl G., 38 Springfield av., Cranford
Herrington, Lee R., 643 E. Broad st., Westfield
Hill, Clarence T., 116 E. Hazelwood av., Rahway
Hippie, Percy L., 118 E. Fifth av., Roselle
Hnat, Frederick, 565 Newark av., Elizabeth
Hoffman, Charles A., 302 E. Seventh st., Plainfield
Holland, Reuben J., 1026 Chandler av., Linden
Holmes, Grace A., 1077 E. Jersey st., Elizabeth
Holt, Evelyn, 261 Springfield av., Summit
Holtzman, Michael, 734 N. Broad st., Elizabeth
Horoschak, Anne, 974 Park av., Plainfield
Horre, George W. H., 203 W. Jersey st., Elizabeth
Hughes, Frederic J., 706 Park av., Plainfield
Humphrey, Hubert G., 430 Downer st., Westfield
Hunt, Thomas F., 528 Monroe av., Elizabeth
Hutton, Frederick T., 726 Watchung av., Plainfield
Imbleau, Joseph E. L., Navy
Jacobs, Alan L., 254 Williamson av., Hillside
Johnson, Harold F., 734 Park av., Plainfield
Jones, Herbert E., Navy
Jones, Lewis H., 139 E. Grant av., Roselle Park
Kandra, Paul H., 76 Washington av., N. Plainfield
Kaplan, Samuel D., Army
Kapp, Carl G., 440 Westminster av., Elizabeth
Karnay, Francis, 348 Pine av., Garwood
Karshmer, Ernest E., 420 Wood av., N., Linden
Katz, Theodore, 927 S. Wood av., Linden
Keeney, Cadwell B., 137 Summit av., Summit
Keil, Sigmund S., 1118 St. George av., E., Linden
Kemeny, George, 39 Third st., Elizabeth
Kible, Milton H., Army
Kidd, Ruth W., 2013 Morris av., Union
Klapper, Lester L., 421 W. Seventh st., Plainfield
Kloby, John J., 562 Bayway, Elizabeth
Knauer, George, 930 Elizabeth av., Elizabeth

Knight, Richard vanD., 129 Summit av., Summit
Konzelman, Henry J., 65 King st., Hillside
Kramer, Douglas W., 1019 Park st., Plainfield
Krans, DeHart, Taunton State Hosp.,Taunton,Mass.
Krans, Edward S., 920 Park av., Plainfield
Kreutz, Paul J., 363 Union av., Elizabeth
Kuchliewski, Edward J., 224 E. Jersey st., Elizabeth
Kushner, Alexander, Army
Kwint, Joseph A., 18 Willow av., Plainfield
Kyle, Ernest I., 205 W. Ninth st., Plainfield
Labow, Joseph J., 757 N. Broad st., Elizabeth
Ladas, George, 305 Cherry st., Elizabeth
Lance, Elton W., 125 W. Milton av., Rahway
Landry, Ernest J., 729 Audrey dr., Rahway
Lang, Louis, 947 E. Jersey st., Elizabeth
Langston, Junius T., 521 E. Second st., Plainfield
Larrabee, Callie H., 24 Hobart av., Summit
Lathrop, Frederic W., 909 Park av., Plainfield
Laurie, Andrew L., 7 W. Grand st., Elizabeth
Lawrence, William H., 129 Summit av., Summit
Leggett, Lindley H., Jr., 330 E. Broad st., Westfield
Leggett, Thomas H., Jr., 706 Park av., Plainfield
Lepree, Joseph A., 45 Hillside rd., Elizabeth
Lerman, Irving, 1024 E. Jersey st., Elizabeth
Lerman, Samuel, Navy
Lewis, Albert, 41 Retford av., Cranford
Lewis, Alexander, 1554 Irving st., Rahway
Lieberman, David P., 597 Westminster av., Elizab'h
Lieberman, Milton L., 101 Pershing av., Roselle Pk.
Lilien, Milton M., 152 Clark st., Hillside
Linke, James J. P., 245 E. Front st., Plainfield
Lippincott, Lansing Y., 939 Park av., Plainfield
Livengood, Horace R., 587 Westminster av., Elizab'h
Llull, Gabriel J., 266 Morris av., Springfield
Losada, Camella A., 19 Prospect st., Summit
Lowell, Milton E., 434 Summit av., Westfield
Lowenstein, Ernest C., Army
Ludlum, Walter D., 257 Harv'd av.,R'ckv'leCtr.,N.Y.
Lufburrow, Charles B., 441 W. Front st., Plainfield
Lyerly, James M., Army
Lynch, Edward T., 748 Livingston rd., Elizabeth
Lynch, Michael F., 1065 Dewey pl., Elizabeth
MacBrayer, Reuben A., 560 Morris av., Summit
MacDonald, Edward O., 719 Locust st., Roselle Park
Mackler, Harry S., 752 N. Broad st., Elizabeth
Maggio, Ross J., 206 Park av., Westfield
Malatesta, Charles S., 1203 Martine av., Plainfield
Mallison, Herbert, 819 Park av., Plainfield
Marone, Carmine R., 752 Newark av., Elizabeth
Maroney, James H., 129 Summit av., Summit
Marts, George H., 956 Park av., Plainfield
Mastroianni, Frank M., Elizab'h Gen. Hosp.,Elizab'h
Maurer, Martha E., 519 Lennox av., Westfield
McAlpine, Paul, Army
McCallion, Wm. H., 722 Westminster av., Elizabeth
McClintock, Elsie, 1439 Maple av., Hillside
McGeary, John A., Army
McGinn, William J., 1913 Westfield av., ScotchPlains
Meeker, John L., 6 De Barry pl., Summit
Meineke, William C., Jr., 818 Chestnut st., Roselle
Mensch, Harvey G., 1117 Mary st., Elizabeth
Merlo, Francis A., 210 Murray st., Elizabeth
Merlo, Francis V., 33 Prince st., Elizabeth
Miller, Robert M., 382 Springfield av., Summit
Milligan, Robert S., 42 Elm st., Summit
Milliser, Estelle T., 126 N. Euclid av., Westfield
Mills, Stephen D., 158 N. Euclid av., Westfield
Minnella, Thomas J., Navy
Mohr, Frank L., 560 Morris av., Summit
Morris, Karl E., 648 E. Broad st., Westfield
Morris, Thomas M., 505 Park av., Plainfield
Morris, Watson B., 193 Morris av., Springfield
Munger, Ray T., 727 Watchung av., Plainfield
Murphy, Herschel S., 320 Chestnut st., Roselle
Murray, Norman L., 129 Summit av., Summit
Nadler, Arthur A., Army
Naidorff, Saul A., 421 W. Seventh st., Plainfield
Neumann, Alfred, 432 Washington av., Linden
Newbury, Graham C., 209 Miln st., Cranford
Nittoli, Rocco M., 660 E. Jersey st., Elizabeth
Novello, Joseph A., 641 Second av., Elizabeth
Nussbaum, Joseph, Army
Obester, Gabriel E., 640 N. Broad st., Elizabeth
O'Brien, Edwin J., Jr., 1200 W. Seventh St., Plainf'd
Oderr, Charles, 121 S. Euclid av., Westfield
Orton, Foster, 196 Elm av., Rahway
Orton, George L., 196 Elm av., Rahway
Orton, Stuart, Navy
Osher, Morris M., 157 North av., Fanwood
Owen, Philip, 1032 Coolidge rd., Elizabeth
Paulson, Arch M., 160 E. Seventh st., Plainfield
Pearl, Sydney S., 837 Park av., Elizabeth
Peters, Richard C., 963 Park av., Plainfield
Poleshuck, Rubin, 100 Hollywood av., Hillside
Polk, Charles C., 114 E. Seventh av., Roselle
Pollack, Louis, 2052 Morris av., Union
Prazak, Beatrice, 500 Monroe av., Elizabeth
Preminger, Max, 822 Park av., Plainfield
Proudfoot, Perry A., 527 Walnut st., Roselle
Prout, Thomas P., 19 Prospect st., Summit
Read, Jessie D., Army
Reale, Frank P., 630 E. Second st., Plainfield
Reich, Jerome J., 1500 N. Broad st., Hillside
Reilly, David F., 44 Prince st., Elizabeth
Reiner, Jacob, 811 N. Broad st., Elizabeth
Reiter, Walter A., 50 DeForest av., Summit
Relyea, George M., 129 Summit av., Summit
Robertson, Grace M., 515 W. Seventh st., Plainfield
Robinson, Anne W., 177 Outer dr., Oak Ridge, Tenn.
Rose, Abraham, 326 S. Broad st., Elizabeth
Rosenblatt, Max B., Army
Rosenstein, Saivel L., 2120 Springfield av., Vauxhall
Roth, Ferdinand L., 98 S. Munn av., East Orange
Rubin, David, 200 E. Jersey st., Elizabeth
Rumsey, Wm. L., Jr., 766 Westfield av., Elizabeth
Runnells, John E., Bonnie Burn San., Scotch Plains
Sadoff, Joseph, 504 Westminster av., Elizabeth
Sagi, Ellen I., 376 Elmora av., Elizabeth
Salvati, Leo H., 275 Orchard st., Westfield
Samuels, S. Lawrence, Kings Co. Hosp.,Br'klyn,N.Y.
Satulsky, Emanuel M., 737 N. Broad st., Elizabeth
Scalessa, Mario F. T., 396 Broad st., Summit
Schenk, Joseph R., 1177 Park av., Plainfield
Schiller, Edwin, 523 Westfield av., Elizabeth
Schiller, Rosa O., 523 Westfield av., Elizabeth
Schilling, Anthony B., 727 Jefferson av., Elizabeth
Schlein, David, 812 N. Wood av., Linden
Schlichter, Charles H., 556 N. Broad st., Elizabeth
Schwartz, Samuel H., 916 Park av., Plainfield
Schweizer, Roman G., 36 Summit rd., Elizabeth
Sell, Frederick W., 167 W. Emerson av., Rahway
Senerchia, Fred F., Jr., Army
Seybold, Arthur D., 1080 Rahway rd., Plainfield
Seymour, George A., 253 Orchard st., Elizabeth
Shangle, Milton A., 34 Prince st., Elizabeth
Shapiro, Max, 414 Elizabeth av., Elizabeth
Sherman, Samuel H., Army
Shirrefs, Russell A., 348 Elmora av., Elizabeth
Silverman, Theodore M., 105 Elmora av., Elizabeth
Sims, Richard V., Jr., 31 Morris av., Summit
Singer, Bella, 640 Wyoming av., Elizabeth
Sly, John L., 382 Springfield av., Summit
Sordillo, Anthony, 1114 Grandview av., Westfield
Spirito, Michael W., 219 S. Broad st., Elizabeth
Spivack, David, 315 W. Jersey st., Elizabeth
Spivack, Seymour E., 405 Chestnut st., Roselle
Stanton, Nathaniel B., 734 Park av., Plainfield
Staub, E. Milton, 505 E. Broad st., Westfield

Steele, Stephen, 10 West Gibbons st., Linden
Stein, Emil, 607 Park av., Elizabeth
Stein, George H., Army
Stein, Isadore, 817 N. Broad st., Elizabeth
Stein, Martin H., 60 Elmora av., Elizabeth
Steinberg, Werner, Army
Stephenson, Gordon A., 145 Summit av., Summit
Stevenson, G. McKay, 129 Summit av., Summit
Strauss, Clifton J., 960 Springf'd av., NewProvid'nce
Strelinger, Alexander, 650 N. Broad st., Elizabeth
Strom, Abraham, 410 W. Seventh st., Plainfield
Stuart, J. Earle, 552 E. Second st., Plainfield
Stybel, Joseph, 806 W. Front st., Plainfield
Suffness, Gustave, 1081 E. Jersey st., Elizabeth
Taranto, Michael, 13 E. Gibbons st., Linden
Tator, Arthur E., 57 DeForest av., Summit
Terrell, Edward E., Army
Thompson, Minturn R., 530 W. Broad st., Westfield
Tidaback, John D., 382 Springfield av., Summit
Tolor, Stanley, 405 Westminster av., Elizabeth
Tomlinson, Rolland D., 505 E. Broad st., Westfield
Townsend, Leslie M., 420 Chestnut st., Roselle Park
Trano, Giovanni, 941 E. Jersey st., Elizabeth
Triarsi, Anthony J., 702 Third av., Elizabeth
Tyndall, Alice E., 263 Walnut st., Westfield
Tyndall, Martha W., 263 Walnut st., Westfield
Vinciguerra, Michael, 604 Westminster av., Elizab'h
Vitale, Dominic V., 749 N. Broad st., Elizabeth
Vitolo, Ralph E., 934 Orchard ter., Linden
Vogel, H. Austin, 1060 E. Jersey st., Elizabeth
Wacker, William F., 1224 Salem av., Hillside
Wade, Simon F., 555 Newark av., Elizabeth
Wagner, Otto, 111 Stiles st., Elizabeth
Wagner, Richard, 260 Tillou rd., South Orange
Walsh, Ronald J., 338 S. Broad st., Elizabeth
Walsh, Thomas J., 335 S. Broad st., Elizabeth
Ward, Leo J., 137 W. Jersey st., Elizabeth
Webb, Eleanor A., 887 Springfield av.,NewProvid'nce
Wegryn, Louis S., 257 Elizabeth av., Elizabeth
Weigel, Edgar W., 210 W. Jersey st., Elizabeth
Weigel, Elmer P., 727 Watchung av., Plainfield
Weissberg, William W., 253 W. 72nd st., N. Y. C.
Weissman, Meyer T., 1137 E. Jersey st., Elizabeth
Weltchek, Herbert, 240 Lincoln av., Elizabeth
Western, Frederic B., Army
Whitken, Albert I., 1056 North av., Elizabeth
Williams, Frank A., 324 W. Jersey st., Elizabeth
Williams, Leonard D., 726 Watchung av., Plainfield
Williams, Manley C., Navy
Wolff, Jerome M., 1414 Martine av., Plainfield
Wolgin, Philip L., 445 Elmora av., Elizabeth
Woody, McIver, 19 Pingry pl., Elizabeth
Wuester, William O., 238 Exter way, Hillside
Yarneli, Helen, 111 E. Front st., Plainfield
Yellin, Charles H., 525 E. Second av., Roselle
Yorke, Edward T., 2300 Summit ter., Linden
Young, Franklin C., 120 Summit av., Summit
Young, Ralph A., 842 N. Wood av., Linden
Yuckman, Robert O., 701 Madison av., Elizabeth
Yuckman, William, 224 W. Jersey st., Elizabeth
Zeitlin, Herman H., 943 N. Wood av., Linden
Zingales, Joseph A., 101 Holly st., Cranford

Number of Active Members and basis of representation, 392.

HONORARY MEMBERS

Guidi, Guido M., Elizabeth
Shirrefs, Russell A., Elizabeth

WARREN COUNTY (21)

Society organized February 15, 1826. Meets on third Tuesday of January, April, July and October, the last being the Annual Meeting.

ACTIVE MEMBERS

Adler, Hubert J., 91 Morris av., Phillipsburg
Baldauf, Herman, Jr., Greenwich st., Belvidere
Bartolini, Frank, 122 Belvidere av., Washington
Bloom, G. Homer, Hillcrest av., Phillipsburg
Boquist, Walter A., 380 Hudson st., Phillipsburg
Bossard, Harry B., R. D. No. 2, Phillipsburg
Bostwick, Wallace R., Main st., Blairstown
Brasefield, Edgar N., 218 Chambers st., Phillipsburg
Buchanan, Ralph M. L., 8 Market st., Phillipsburg
Cioffi, Eugene, 137 Belvidere av., Washington
Drake, Paul F., 85 Summit av., Phillipsburg
Gordon, Frank S., Blairstown
Humbert, Joseph C., Jr., Stewartsville
Jackson, Elmer C,. Blair Academy, Blairstown
Kassow, Philip B., North Blvd., Alpha
Kimmel, Seymour S., Oxford
Krausz, Emery, 577 S. Main st., Phillipsburg
Lemmon, Junius M., 28 W. W'sh'gt'n av.,Wash'gt'n
Lyon, Charles H., 79 Lewis st., Phillipsburg
Marlett, Neumann C., Navy
Maxwell, Carl A., Army
Michell, George E., 221 High st., Hackettstown
Potter, Charles W., 184 Belvidere av., Washington
Shevitz, David M., 212 Grand av., Hackettstown
Shimer, Floyd A., 88 Lewis st., Phillipsburg
Smith, Herman, 306 Bates st., Phillipsburg
Smith, J. Meredith, Navy
Spillane, Timothy H., 379 S. Main st., Phillipsburg
Varney, William H., 122 Belvidere av., Washington
West, Guernsey F., 109 S. Main st., Phillipsburg
Wolf, Frank A., 494 S. Main st., Phillipsburg
Zuck, Arthur C., 22 Broad st., Washington

Number of Active Members and basis of representation, 32.

MEMBERSHIP SUMMARY

County	Total		In Service	
	Active	Associate	Active	Associate
Atlantic	130	11	26	2
Bergen	317	12	52	..
Burlington	67	..	7	
Camden	205	..	26	..
Cape May	30	..	3	..
Cumberland	63	..	4	..
Essex	1232	35	170	6
Gloucester	45	..	2	..
Hudson	432	..	83	..
Hunterdon	28	..	3	..
Mercer	244	18	25	2
Middlesex	178	20	26	1
Monmouth	132	12	9	
Morris	125		19	..
Ocean	30	3	4	..
Passaic	404	22	37	7
Salem	29	..	4	
Somerset	63	..	16	
Sussex	30		3	..
Union	392	..	31	..
Warren	32	..	3	..
Totals	4208	133	553	18

The New York Academy of Medicine

DUE IN TWO WEEKS UNLESS RENEWED.
NOT RENEWABLE AFTER 6 WEEKS

DATE BORROWED	BORROWER
JUN 3 1907	
OCT 4 1909	